PREVENTION report

U.S. Department of Health and Human Services Volume 12: Issue 3 1997

Putting Prevention Into the Context and Continuum of Women's Lives

In this last decade of the 20th century, interest and commitment to women's health have heightened. Milestones range from the addition of "women's health" as a subject heading in MEDLINE® to the inauguration of national conferences on women's health and the *Journal of Women's Health*, the launching of a 40-site clinical trial, and the establishment of offices on women's health throughout the U.S. Department of Health and Human Services (HHS) and in 5 States. Women, who represent half of the Nation's population, benefit from every step closer to the overarching Healthy People 2000 goals of reducing disparities and achieving access to preventive services. Yet, despite remarkable progress on some Healthy People 2000 women's health objectives, many have not been achieved.

Prevention in women's health traditionally has focused on reproduction, but women have other health priorities. In younger women, for example, staying healthy encompasses establishing good nutritional habits, making physical activity a daily routine, and never smoking. In older women, preventing injuries due to falls is just one of many ways to protect the quality of life.

Women and health professionals need to learn more about what promotes or reduces women's health—gender factors, as well as age, occupation, cultural factors, socioeconomic status, education, and family history. Certain diseases affect women exclusively, such as ovarian and cervical cancers; disproportionately, such as breast cancer, depression, and osteoporosis (see *Spotlight*); or differently, such as cardiovascular diseases, HIV/AIDS, and asthma.

Differences exist in the identification and modification of risk factors

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This issue of Prevention Report *focuses on clinical preventive services and women. Women's health, a national public health priority, encompasses much more than these services and the traditional areas of reproduction and childbearing. Different disease conditions uniquely affect women, such as heart disease, AIDS, smoking, and alcohol and other drug dependency and abuse. Other problems affect women's health, including sexual assault and harassment, domestic violence, stress in the workplace, and aging. Indeed, Federal agencies, States, local communities, businesses, and organizations seeking to coordinate and enhance women's health services and programs often start with an audit of current activities and a needs assessment. Priority setting, funding and staffing, program design and implementation, and many more challenges follow. For more information on women's health in general, see* Resources.

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OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

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DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Heart Disease: Not for Men Only

Heart disease is the number one killer of American women. Of the nearly 500,000 heart attack deaths that occur each year, more than 239,000 occur in women. More than 90,000 women die each year of stroke.

Women can change these numbers by changing their lifestyles to reduce major risk factors: Smoking, high blood pressure, high blood cholesterol, diabetes, obesity, and physical inactivity.

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for diseases and in the diagnosis and treatment of diseases. Despite the fact that women utilize the health system more often than men, they are less compliant, perhaps because of their own attitudes and practices, as well as their physicians' attitudes. In addition, diagnostic testing and therapeutic procedures for women are inadequate.

Research in women's health has also been inadequate. Gender differences in areas ranging from clinical practices to understanding basic mechanisms of disease have not been explored fully. Women's symptoms can be misinterpreted. For example, some symptoms of heart disease, the number one killer of women, are different from symptoms typical for men. Physicians do not look for AIDS symptoms in women as early as in male patients, with a resulting delay in effective treatment.

The women's health agenda, however, is growing, due to increased congressional funding, the Clinton administration's support, and public attention.

At a national conference in November, the Office of Research on Women's Health at the National Institutes of Health was expected to develop the research agenda on women's health for the 21st century. Plenary sessions and working groups were planned with particular emphasis on emerging gaps in knowledge about women's health across the life span, laboratory bench to bedside research issues, health status of minority women and other special populations, and career issues for women scientists.

The U.S. Public Health Service's Office on Women's Health (OWH) within HHS has a mission to improve the health of women across the life span. To foster an increased focus on women's health across the Nation, this past summer the office sponsored the National Women's Health Leadership Summit, which brought together representatives from every State and territory in the United States. They were briefed on HHS programs, managed care, and welfare reform. OWH seeks to redress inequities in research, health care services, and education that have placed the health of women at risk.

Health-Seeking Behavior

Not taking preventive health measures to protect against serious illness and not receiving screening for detecting treatable disease are associated with women's health-seeking behavior: National Health Interview Survey data from the early 1990's showed that 39.4 percent of women aged 50 and above had not received a screening mammogram in the past 2 years; 35 percent of women aged 18 and above had not received a Pap smear in the past 3 years; and 21 percent of women aged 18 and above had not received a blood pressure test in the past year. One of the study's most revealing findings was that three in five women aged 18 and over reported risk behavior in at least one of the identified risk factor categories of smoking, diet, exercise, and alcohol or drug use. Yet, the majority had not been asked about these behaviors during their last checkup.

In another study of health-seeking behavior, women with abnormal Pap smears were more likely to get followup than women with normal results, but two out of five did not get followup care. A study involving cervical cancer control showed that even with followup, many women did not complete all recommended treatments. Similarly, a hormone replacement study concluded that prescribing physicians should be aware of the noncompliance rates and try to increase their patients' adherence to therapy.

Counseling: Not for Women Only

According to recent studies, physicians and other health care professionals should improve their skills in taking sexual histories and in counseling male patients about HIV/AIDS, other sexually transmitted diseases, and topics often considered "for women only" but where men play a key role. Health care professionals also need to counsel all patients on disease prevention. For example, evidence indicates that middle-income women are diagnosed with AIDS much later than their male counterparts—with negative implications for treatment—because health professionals do not recognize the symptoms: They incorrectly believe that some patients simply are not at risk for HIV infection and do not need prevention counseling or diagnosis.

Barriers to Prevention

What keeps women from getting needed services? Women mention transportation and cost difficulties, scheduling problems, and motivational issues. The very programs that could most effectively increase screening rates sometimes have had to limit recruitment because the demand for clinical services exceeds the resources. In other cases, financial constraints prevent key services from being publicized and provided to all eligible women and limit the ability of women to enter the health system.

Barriers to preventive services can be divided into these categories: system factors (costs and lack of coverage; accessibility; inconvenient appointment process and time), motivation (deciding to go, making appointments, finding transportation), concerns about procedures or results; time/role conflicts; and forgetting.

Access and insurance are critical issues for a number of reasons. Women on the average earn less than men and make up a larger portion of the population holding jobs that usually do not have health insurance. Many women rely on their spouses for health insurance and risk being dropped if they are divorced or widowed. Women bear the major responsibilities for the health needs of uninsured children, including women of the next generation. Women live longer and have more chronic illnesses and conditions, needing access to specialists and lifelong treatments, which often cost more.

In terms of preventive services, many women are underserved, including women over age 50, persons with low incomes, members of racial and ethnic minority groups, residents in rural areas, and undereducated women. Women also are likely to be underinsured as well as underserved.

Studies show that women may lack perception of risk—they lack awareness and knowledge that certain diseases have prevention options (see *Spotlight*). A woman's own physical condition also can be a deterrent. Overweight women, for example, may not seek care because of poor body image; their diagnosis may be complicated by the weight; and their physicians' attitudes may affect care negatively.

Some women are not assertive in seeking health care, waiting for their physician to recommend services, such as mammography. Thus, providers have an increased responsibility for patient education about preventive screening services that can reduce morbidity and mortality.

Lack of reminders about needed care is cited often. The Colorado Department of Health uses a statewide computerized system to track the screening status of 150,000 women for their lifetimes and issues reminders to mammography providers. Other strategies include integrating preventive services at primary health care sites and community-based outreach programs.

At another level, women do not make their own health a priority; they are too busy balancing work and family obligations. The Food and Drug Administration's Office of Women's Health has piloted the "Women's Health: Take Time To Care" educational outreach program to help women take better care of themselves, for their own sake and for their families. The pilot featured

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Health is a positive state, not merely the absence of disease. Each of us has primary responsibility for maintaining this most precious asset. Being well informed about our bodies is the key to staying healthy.

Bernadine P. Healy, M.D.[1]

[1] Bernadine P. Healy, M.D., former director of the National Institutes of Health, who launched the Women's Health Initiative, the most ambitious clinical study in history to examine the leading causes of morbidity and mortality in postmenopausal women. She now is Editor-in-Chief of the *Journal of Women's Health* and Dean of the College of Medicine at The Ohio State University.

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outreach to minority communities and joined with pharmacists about using medicines wisely. FDA also has developed educational programs about teenage smoking and increased calcium consumption among female teenagers.

Certain groups of women face particular problems getting needed services. Sexuality can be a factor. For example, lesbians are at greater risk for some diseases, such as lung cancer, but may be unaware of the risks, may not seek help, and may not get sensitive care.

Chronically ill and disabled women may face more problems than most women, including more difficult access to health care. Sometimes the problem is just equipment—an examination table low enough for a disabled woman to get on and off. A mammogram reading may be inadequate because the woman cannot get into the proper position (new equipment design is alleviating this problem). Sometimes physicians are more focused on the disability and do not pursue preventive needs, such as pregnancy counseling.

Women in prison represent a growing phenomenon for justice and health officials. Many facilities face difficulty in providing adequate health care and supportive services for women.

Women's Health in the Future

Efforts to increase clinical preventive services for women include establishing more integrative women's health services, such as "one-stop shopping" centers for all aspects of women's clinical care as part of a health system or standalone facility.

Select Resources

A recent search of women's health resources on the Internet produced hundreds of thousands of links, many pointing to more references. Here is a sampling of publicly and privately sponsored sites:

Agency for Health Care Policy and Research—consumer information and clinical practice guidelines; topics of concern to women include mammograms and smoking cessation. *http://www.ahcpr.gov/consumer/*

American Heart Association
http://www.amhrt.org/resources.html

National Action Plan on Breast Cancer, a public/private partnership coordinated by the PHS Office on Women's Health.
http://www.napbc.org/

National Association of Women's Health Professionals, a nonprofit, nonpartisan, professional membership association that brings together a growing constituency of professionals from a broad range of disciplines, all with a common interest in improving health outcomes for women. *http://www.nawhp.org/*

National Heart, Lung, and Blood Institute—publications on women and heart disease.
http://www.nhlbi.nih.gov/nhlbi/edumat/pub_list.htm

National Institute on Aging—publications related to women's health, including menopause.
http://www.nih.gov/nia/health/health.htm

National Women's Health Resource Center—*National Women's Health Report*, a newsletter filled with information about preventive care; Women's HealthInfo Search, a topic-specific research service; and the Healthy Women Database, a list of women's health organizations, hospitals, health centers, publications, videos, and web sites.
http://www.healthywomen.org/

Office of Women's Health, Food and Drug Administration—information for women on food safety, nutrition, and cosmetics.
http://www.cfsan.fda.gov/~dms/fdacowh.html

Office on Women's Health, Public Health Service
http://www.4woman.org/nwhic/ucowh.htm

Office of Research on Women's Health, National Institutes of Health—online publications catalog and order form.
http://ohrm.od.nih.gov/orwh/orwhpubs.html

Women's Health Electronic Network, a current directory for people working in academic and community aspects of women's health so that they can network with each other. *http://www.library.utoronto.ca/www/wch/network.html*

Women's Health Interactive, a web site where women can communicate directly with health care professionals, join a discussion group, or assess their own situation through the use of health profiles.
http://www.womens-health.com/

Women's Health WEEKLY covers current research and news stories specifically relating to women's health; sample issues of this news weekly can be downloaded and subscription issues obtained by e-mail; includes comprehensive, searchable public and subscription databases and a calendar of women's health events and meetings.
http://www.newsfile.com/homepage/1w.htm

In medical education and research, there is a need for women's health curricula and studies. In addition, more women need to be recruited into health leadership positions.

For many American women, prevention is not yet a household word. Women need information and encouragement to seek services and take steps to reduce risks. Women also need counseling from health professionals, referral for screening, and reductions in barriers, such as lack of insurance, lack of transportation, and work and child care difficulties. As practiced, some managed care programs have built-in incentives to prevent access to costlier care. Improving clinical care of women depends on increasing knowledge of women's health issues throughout each phase of the life cycle. Women need to know the facts so that they can exercise the necessary preventive vigilance. They also need the support of their families, health care professionals, and health systems, as well as the health information media and their communities as a whole.

Developing Healthy People 2010

On September 15, 1997, a new web site opened to accept public comments on Healthy People 2010—the U.S. health goals for the first decade of the next century. This event coincided with the fall meeting of the Department of Health and Human Services (HHS) Healthy People Steering Committee. Dr. Claude Earl Fox, Acting Administrator of the Health Resources and Services Administration, is serving as the chairperson of the Committee.

The new URL address, http://web.health.gov/healthypeople, was announced in the *Federal Register* on September 5. This notice calls for public comments on the proposed structure of Healthy People 2010—its goals, focus areas, and focus area arrangement. (See next page.) Commenters also have an opportunity to suggest modifications and deletions to existing Healthy People 2000 objectives, as well as proposals for new objectives. Comments received by December 15, 1997, will be used for a draft Healthy People 2010 document to be published for public comment in the fall of 1998.

Members of the Healthy People Steering Committee represent each operating division of HHS and each staff division in the Office of Public Health and Science. They meet quarterly to address policy issues and provide overall guidance to the initiative for the Assistant Secretary for Health. The work of the committee is coordinated by the Office of Disease Prevention and Health Promotion (ODPHP).

In addition to observing a demonstration of the new homepage, the Committee addressed numerous issues related to Healthy People 2010. Staff of the Centers for Disease Control and Prevention, National Center for Health Statistics, discussed data sources and tracking issues. Staff of the Public Health Foundation provided preliminary results on the ability of the States and localities to measure their own objectives. The Committee also discussed data development for Healthy People and how it relates to budget performance measures being introduced in the fiscal year 1999 Federal budget. The committee was called on to continue examining how Healthy People contributes to performance measurement and vice-versa.

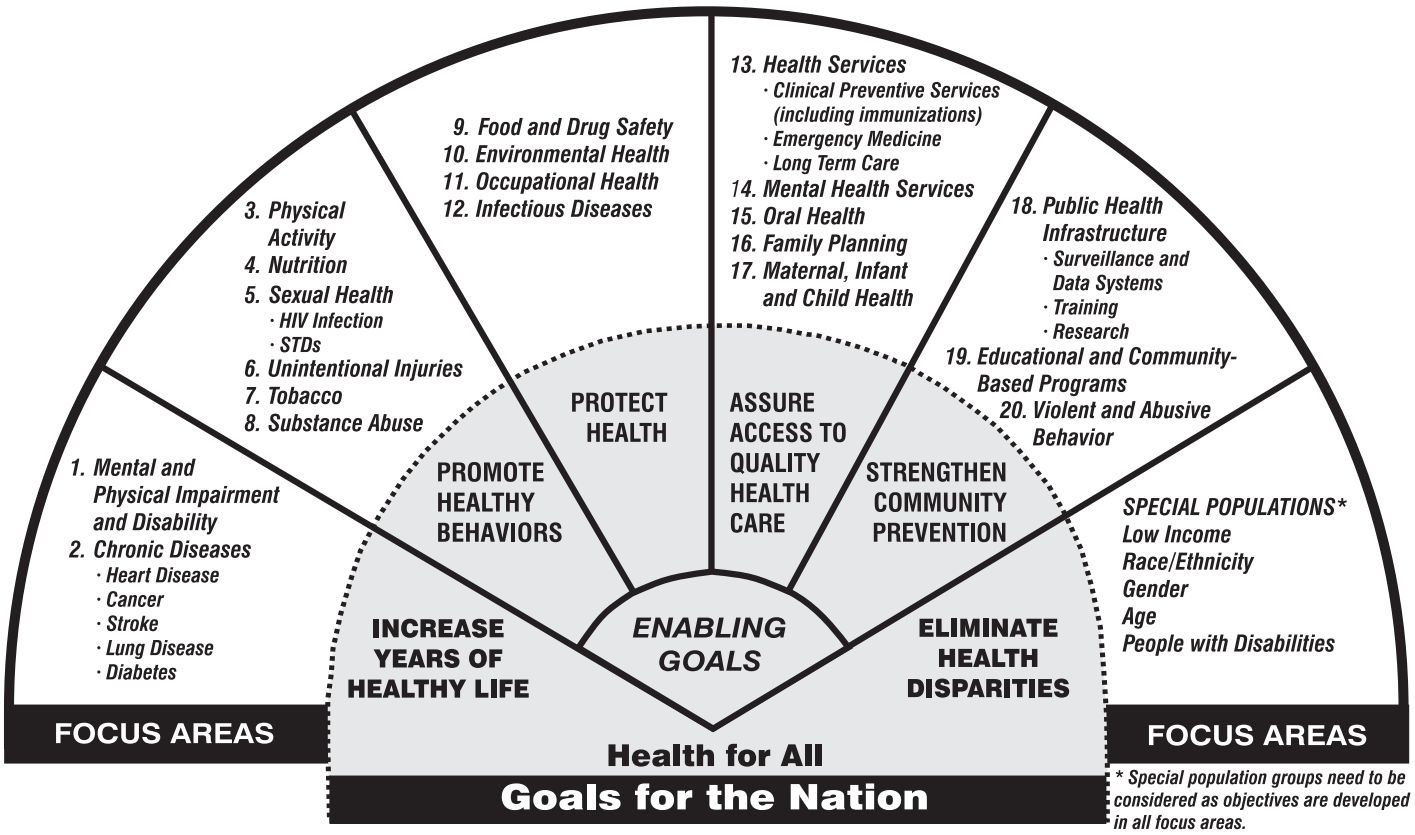
Staff from the Office of Minority Health led a discussion on the cross-cutting focus areas proposed in the 2010 framework. Theoretically, there is no need for population subgroups to have separate chapters in the Healthy People 2010 document, provided their particular interests are addressed in all focus areas. ODPHP staff presented an outline of a draft chapter of the 2010 document and invited input on standardizing material to accompany the objectives.

The Executive Director of the Partnership for Prevention spoke about the formation of the Healthy People 2010 Business Advisory Council to engage corporate support and input for 2010. Plans are to have 20 to 25 members representing large, medium, and small businesses, including firms owned by minorities and women. Consideration is also being given to including representation from labor unions. This project received funding for a 2-year period on July 3, 1997, from the Robert Wood Johnson Foundation.

Using the Internet is truly opening the Healthy People development process to the public and furthering the participatory processes that this initiative has been built on.

PROPOSED HEALTHY PEOPLE 2010 FRAMEWORK

Vision of 2010:
Healthy People in Healthy Communities



To comment on the proposed structure of Healthy People 2010, visit
http://web.health.gov/healthypeople

Send written comments to:
Healthy People 2010
Office of Disease Prevention and Health Promotion
Room 738G, Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201

Public Comment: September 15-December 15, 1997

Osteoporosis: Prevention Across the Ages

Women 50 years of age and older now represent nearly two out of five females in the United States and a growing population at greater risk for osteoporosis. This condition results in gradual bone loss that can lead to crippling fractures. There are currently about 23 million women with bone loss at risk of osteoporotic fractures.

Prevention of osteoporosis has become more important as women's health has gained in priority (see *Focus*), as the female population continues to age, and as treatment costs climb. Treating osteoporotic fractures costs more than $38 million per day—$14 billion a year and growing.

Varied Prevention Efforts

Today, osteoporosis prevention spans all age groups, incorporates new research, and encompasses many public and private organizations. Earlier this year, the Food and Drug Administration approved the first new drug, alendronate (Fosamax®), to prevent osteoporosis in postmenopausal women since estrogen was okayed 8 years ago. For postmenopausal women, prevention choices also include calcium supplementation and keeping active. Younger women who practice healthy lifestyles, including regular weight-bearing exercise and proper nutrition with adequate amounts of calcium and vitamin D, can have a major impact on osteoporosis prevention.

Like other women's health issues, the emphasis is on taking action today to prevent osteoporosis tomorrow. The search for new solutions continues, too. Researchers are exploring causes of osteoporosis and risk factors, new prevention and treatment drugs, new screening and detection technologies, fall and fracture prevention behaviors, and issues related to preventing osteoporosis as a secondary or comorbid condition. Researchers also are examining the needs of specific populations, including minority groups, men, and high-risk groups such as young female athletes, people with anorexia, and people taking medications that may compromise their bones.

What women of all ages and their health caregivers need is information to make decisions about what forms of osteoporosis prevention are best for themselves, including hormone replacement therapy (HRT) (see *In the Literature*). Some women avoid even considering the tradeoffs of HRT because their fear of breast cancer is unproportional to its risk: breast cancer accounts for 4 percent of deaths in women, but heart disease, which HRT may help to prevent, causes 33 percent of the deaths of women in this country.

Increasingly, getting much-needed health information to women depends on public/private partnerships, such as the Osteoporosis and Related Bone Diseases National Resource Center. The resource center is operated by the National Osteoporosis Foundation (NOF) with a grant from the National Institute of Arthritis and Musculoskeletel and Skin Diseases in collaboration with the Paget Foundation and Osteogenesis Imperfecta Foundation. The center has been established with public funds and knowledge coupled with private sector knowledge, history of information services, and energy. NOF has a strong science base and promotes research on the epidemiology, pathogenesis, diagnosis, and treatment of osteoporosis.

Information Sources

The resource center has a toll-free number (800-624-BONE). Web sites (http://www.osteo.org and http://www.nof.org) provide information to health professionals, patients, and the public. A number of other web sites provide information on osteoporosis.

NOF has also partnered with the U.S. Public Health Service's Office on Women's Health in an Osteoporosis Education Campaign targeting adolescent girls to raise awareness of the disease and preventive behaviors.

Osteoporosis prevention and treatment efforts also are taking place at State and local levels. In January, NOF joined with the New York City Department of Health and the New York City Commission on the Status of Women to publish *A Resource Guide to Osteoporosis Services in New York City*. In October, NOF, Eli Lilly and Company, and the shopping centers of Ere Yarmouth sponsored "America Walks for Strong Women" in six cities to raise awareness in women about osteoporosis prevention.

IN THE LITERATURE

Women's Health

Cancer Coverage and Tobacco Advertising in African-American Women's Popular Magazines. L. Hoffman-Goetz, et al. *Journal of Community Health* 22 (August 1997): 261-69.

Tobacco-related cancers are entirely preventable and contribute to the significant cancer burden of African-American women. Covering such cancers in magazines targeting these women presents an opportunity to promote preventive health behavior.

Tobacco ads and articles on cancer, cardiovascular disease, and general health were examined in three major magazines targeted to African-American women—*Ebony, Essence,* and *Jet.* Of 649 general health articles, 84 discussed cancer in general; only 9 covered tobacco-related cancers. The number of tobacco ads reached nearly 1,500 during the January 1987–December 1994 period studied, with the number per year declining over time and varying significantly by magazine.

In 1992, lung cancer surpassed breast cancer as the leading cause of cancer mortality among African-American women, but none of the three magazines published an article on lung cancer after that year. In those articles focusing on lung cancer, tobacco rarely was discussed as the major contributing cause.

Journal of Women's Health 6 (August 1997)

Women's Beliefs and Decisions About Hormone Replacement Therapy. K.M. Newton, et al. 459-65.

With a better understanding of the beliefs and decisions that influence women's choice to use hormone replacement therapy (HRT), providers can develop more effective strategies for helping women make informed choices about HRT.

A study of women's beliefs about HRT was conducted at Group Health Cooperative of Puget Sound, a health maintenance organization providing medical care to more than 370,000 people in western Washington. The study design featured random sampling of 1,520 women, oversampling in minority populations, and as many as 26 attempts to reach the sample. Of the 1,345 women reached, 1,120 (80.3 percent response rate) agreed to participate and completed the telephone interview. The final sample included 1,082 women who were classified as perimenopausal (very irregular or infrequent periods) and menopausal/postmenopausal, as well as current HRT users, past users, or never users.

Current and past users mentioned most frequently these reasons for their use of HRT: menopause-related symptoms (48.7 percent), osteoporosis prevention (32.6 percent), and physician advice (29.6 percent). Cardiovascular disease prevention was mentioned by 15.6 percent of current and 5.3 percent of past users. Of past HRT users, 53.8 percent reported stopping on their own, with the balance doing so on their physician's advice. The most frequently cited reasons for never using HRT were not needing hormones (49.9 percent) and viewing menopause as a natural event for which medications were unnecessary (17.9 percent). Fear of cancer (12.9 percent) and other side effects (12.9 percent), as well as physician advice (13.3 percent), were other reasons given for not initiating HRT.

Many women appear unaware or unconvinced of the potential role of HRT in cardiovascular disease prevention and misinformed about its role in osteoporosis prevention. Women need information from multiple sources—repeated counseling by health care providers as well as printed materials—to assess the risks and benefits of HRT, to make informed decisions, and then to reassess their earlier decisions.

Perceptions of Menopausal Stage and Patterns of Hormone Replacement Therapy Use. L.A. Bastian, et al. 467-75.

HRT use is associated with a woman's perception of her menopausal stage. To help women make informed decisions about HRT, health professionals should increase women's knowledge base about reproductive aging.

As part of ongoing data collection in the University of North Carolina Alumni Heart Study, women were asked about their menopausal stage and HRT use. Data were analyzed from mail questionnaires completed by 1,101 women aged 45-51. Menopausal stage was self-identified and not verified with hormone levels or medical record reviews. The women identified their menopausal stage as not near menopause (stage 1) (30

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percent), may be close to menopause but not sure (stage 2) (38 percent), have begun menopause (stage 3) (19 percent), and have been through menopause (stage 4) (13 percent). No respondents in stage 1 were using HRT; 8 percent in stage 2, 52 percent in stage 3, and 76 percent in stage 4 were using HRT. Significant independent predictors of HRT use included menopausal stage, having had a hysterectomy, having had a pelvic exam in the past year, being married, and not participating regularly in physical exercise.

Nutrition

Population Nutrient Intake Approaches Dietary Recommendations: 1991 to 1995 Framingham Nutrition Studies. B.E. Millen, et al. *Journal of the American Dietetic Association* 97 (July 1997): 742-49.
Preventive nutrition messages should target the differing dietary patterns of men and women by focusing on specific nutrients, such as increasing folacin for women and complex carbohydrates for men.

A cross-sectional analysis was conducted of nutrient intake estimated from 3-day food records for 2,520 adults (1,375 women and 1,145 men) surveyed in the Framingham Offspring-Spouse Study between 1991 and 1995. Study objectives were to estimate population nutrient intake levels and to assess adherence to current dietary recommendations.

Between 1991 and 1995, high proportions of Framingham men and women (70 percent or more) achieved nutrient intake levels compatible with national preventive nutrition recommendations. Large proportions of adults did not meet the guidelines for some key nutrients. Statistically significant gender differences were noted, with more women than men meeting recommendations for carbohydrate, total and saturated fat, cholesterol, vitamin A, beta carotene, and sodium. More men than women met the guidelines for monounsaturated fat, dietary fiber, vitamin B-12, folacin, and calcium.

Food Intakes of U.S. Children and Adolescents Compared With Recommendations. K.A. Munoz, et al. *Pediatrics* 100 (September 1997): 328-29.
Many youth are not meeting the national Food Guide Pyramid recommendations for food group intake and need nutrition education and intervention. Adolescent females, minorities, and children from low-income households especially need dietary modification.

This study examined the food intake of 3,307 youth aged 2 to 19 years according to demographic characteristics, patterns of intake, and nutrient profiles associated with each pattern. Children did not meet recommendations, especially for fruit, grain, and dairy. Their intake of total fat, discretionary fat, and added sugars constituted 40 percent of total energy intake, well above recommendations for fat and sugars. Sixteen percent of youth did not meet any recommendations; 1 percent met all recommendations. Not meeting any intake recommendations resulted in intakes well below the recommended dietary allowances for some nutrients. Differences were noted for gender, race/ethnicity, and poverty level. Also, children's intake patterns differed from those observed among adults.

Educational and Community-Based Programs

Health Education & Behavior 24 (August 1997)
Recruitment and Training Issues From Selected Lay Health Advisor Programs Among African Americans: A 20-Year Perspective. E.J. Jackson and C.P. Parks. 418-31.
Lay health advisors (LHA's) are highly valuable in the helping and networking processes of their communities and benefit from clearly defined recruitment and training geared toward their roles. Appropriate training of LHA's fosters cooperative relationships with health professionals, enhances the potential to mobilize community resources, and offers new services and programs to the community.

The Community Health Education Program (CHEP) served as a guide for exploring the evolution of recruitment and training procedures in LHA programs for African Americans. CHEP represents one of the first fully documented LHA programs in the United States implemented in two predominantly African-American communities and based on the natural helper concept. The most effective CHEP recruitment methods were area organizations, program coordinators, people in key positions and occupations, and previously trained LHA's. Initial training was based on extensive planning and cooperation with program staff, community residents, and agency representatives after

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which the LHA's assumed a role in planning trainings that addressed their specific needs and interests.

The authors reviewed 87 LHA programs implemented among American Americans from the 1960's to 1994, focusing on recruitment and training procedures. Community-level recruitment techniques were identified as effective, suggesting that greater attention should be paid to the recruitment process for African-American LHA's. Four training issues merged—the dearth of information on specific training protocols used by African-American LHA programs, the large percentage of programs that pay for LHA services, thus professionalizing many LHA's; inconsistency in training methods and requirements; and possible mismatch between program goals, topics covered, and the natural helping role of LHA's. In sum, many of the training procedures reviewed by the authors fell short in their ability to assist LHA's in their community roles.

The Latino Health Advocacy Program: A Collaborative Lay Health Advisor Approach. E.A. Baker, et al. 495-509.
When community members take an active role in the initiation, design, implementation, and evaluation of local health care programs, they are more likely to use the programs.

The Latino Health Advocacy Program, a pilot program based in Worcester, MA, featured these components: forming linkages with health and human service agencies, working one-on-one with clients, and conducting community outreach. Through written summaries of interviews and meetings, community outreach forms, intake forms, and handwritten and tape-recorded progress notes, the program was evaluated as useful in increasing community access to and improving use of services. Because of the program's holistic approach, LHA's were able to address the underlying causes of problems, not just the symptoms. In addition, community health fairs helped LHA's share health information and information about resources. Finally, the agency linkages helped LHA's eliminate barriers to services.

Occupational Safety and Health

Occupational Fatalities Among Older Workers in the United States: 1980-1991. S.M. Kisner and S.G. Pratt. *Journal of Occupational and Environmental Medicine* 39 (August 1997): 715-21.
From 1992 to 2005 the number of workers aged 55 years and older is projected to grow 38 percent, increasing the importance of identifying job-related risks of injury and death and developing preventive work practices. Specifically, prevention efforts should focus on older workers in agricultural settings, as well as those at increased risk of workplace falls or violence.

Death certificates for persons 16 years of age or older with an "external" cause of death and a positive response to the "Injury at Work" item were examined from 52 U.S. vital statistics reporting units (the 50 States, New York City, and the District of Columbia). For the 12-year period, 1980 through 1991, there were 5,218 fatalities among full- and part-time workers aged 65 years and older. Older workers (aged 65 and older) had a fatality rate 2.6 times higher than that of younger workers (aged 16-64). The four leading causes of death for older workers were machinery-related incidents (28 percent), motor vehicle-related incidents (18 percent), homicide (13 percent), and falls (13 percent). Compared with younger workers, older women were at increased risk for fatal falls and homicide, and older men for fatalities caused by machines. The highest work-related industry division fatality rates were mining (62.7 per 100,000 workers), agriculture/forestry/fishing (52.6), construction (40.2), and transportation/communications/public utilities (33.2).

Oral Health

Journal of the American Dental Association 128 (July 1997)
Fluoride concentrations of infant foods. J.R. Heilman, et al. 857-63.
To prevent dental fluorosis, a tooth discoloration caused by excessive fluorine, caregivers should monitor an infant's total fluoride intake, especially infant foods containing chicken.

The researchers analyzed 206 ready-to-eat infant foods and 32 dry infant cereals manufactured by two different companies. Fluoride concentrations varied greatly, with foods containing chicken having the highest concentrations. Fluoride levels depended largely on the processing locations because of the different types of water used (fluoridated or nonfluoridated). Researchers noted that the fluoride level of the water used to reconstitute dry cereal is generally a more important determinant of fluoride intake than the fluoride level of the cereal itself.

The high fluoride content of infant foods containing chicken may be due to the mechanical deboning process. Foods containing fruits and vegetables are, in contrast, much lower in fluoride, but specific fluoride levels also depend on the water source used during processing.

Assessing the Cariogenic Potential of Some Infant Formulas, Milk, and Sugar Solutions. W.H. Bowen, et al. 865-71.
Dental practitioners and other health professionals should discourage the use of sugar in baby bottles and provide information on which formulas are least likely to induce caries when continuous bottle feeding is unavoidable.

Two separate rat studies were completed 1 year apart to test a total of 10 formulas. The rats were desalivated to match better the low-saliva condition of a baby sleeping with a bottle in its mouth. The control groups received sucrose or plain water by stomach tube; the remaining groups received a variety of infant formulas. Common in the two experiments were 5 percent sucrose and Gerber Baby Formula with Soy (Gerber). After the 17-day investigations, the rats' lower jaws were removed and tested. The researchers classified the tested formulas by ranking their cariogenic potential: negligible to low (milk, ProSobee, Carnation Follow-Up, Lactofree, Nutramigen, and Isomil); modest to moderate (Nursoy, Enfamil, and Gerber Baby Formula with Soy); and moderate to high (Similac Low-Iron Infant Formula and Gerber Baby Formula Low-Iron). The highest caries scores were observed in the rats that ingested the sucrose water. Of all the fluids examined, plain milk was by far the least cariogenic.

Maternal and Infant Health

Predictors of Injury Mortality in Early Childhood. S.J. Scholer, et al. *Pediatrics* 100 (September 1997): 342-47.
By focusing on maternal characteristics, health professionals can prevent serious injuries and deaths among high-risk children age 1 through 4 years. In particular, managed care organizations that serve high-risk populations, including low-income Medicaid mothers, are attractive settings for injury prevention programs.

Injuries are the leading cause of death for children of these ages. Recent data suggest that mortality rates for some injuries may be increasing.

In a study of 803 child deaths from injury, these maternal characteristics were associated, strongly and independently, with increased risk of mortality from injury: low education, young age, and increased number of children. The study did not identify potentially important environmental and behavioral factors associated with injury risk, such as use of child vehicle restraints or parental supervision. Researchers suggested that the maternal characteristics might serve as convenient surrogates for such factors, stating, for example, that the strong association between injury mortality and number of other children probably reflects the effects of supervision.

Heart Disease and Stroke

Prevention of Heart Failure by Antihypertensive Drug Treatment in Older Persons With Isolated Systolic Hypertension. J.B. Kostis, et al. *Journal of the American Medical Association* 278 (July 16, 1997): 212-16.
The stepped-care drug treatment can exert a strong protective effect in preventing heart failure in older persons with isolated systolic hypertension (ISO).

A double-blind, randomized, placebo-controlled, multicenter clinical trial tested the efficacy of diuretic-based stepped-care antihypertensive drug treatment on the occurrence of heart failure in older persons with ISO. The Systolic Hypertension in the Elderly Program studied 4,736 persons aged 60 and older with systolic blood pressure (SBP) between 160 and 219 mm Hg and diastolic blood pressure below 90 mm Hg. The step 1 drug was chlorthalidone or matching placebo; the step 2 drug was atenolol or matching placebo. In the active step-care therapy group, participants experienced fatal or nonfatal heart failure (HF) less frequently than the placebo group. A lower rate of HF was noted with active treatment in these risk categories: men, older participants, and persons with higher baseline SBP. Among patients with prior myocardial infarction, researchers observed an 80 percent risk reduction.

ACTIVITIES

MEETINGS

National Congress on Childhood Emergencies: Community Partnerships, Clinical Care, and Policy. Washington, DC. For information, contact Ken Allen at (202) 884-4927 or e-mail kallen@emscnrc.com. **March 22-24, 1998.**

"Health Promotion Across the Lifespan," 9th Annual Art & Science of Health Promotion Conference. Sponsored by the *American Journal of Health Promotion*. Monterey, CA. For more information, call (248) 682-0707 or fax (248) 682-1212. **March 23-28, 1998.**

"Prevention 98: Translating Science Into Action." San Francisco, CA. For information, contact Prevention 98 at (202) 466-2569 or prevention@acpm.org, or write 1660 L Street, NW., Suite 206, Washington, DC 20036. **April 2-5, 1998.**

"Change: The Only Constant." American Alliance for Health, Physical Education, Recreation, and Dance Annual Meeting: Reno, NV. For more information, call (703) 476-3400. **April 5-9, 1998.**

American Society for Clinical Nutrition Annual Meeting. San Francisco, CA. For more information, call (301) 530-7110. **April 18-20, 1998.**

American Society for Nutritional Sciences Annual Meeting. San Francisco, CA. For more information, call (301) 530-7050. **April 19-22, 1998.**

National Rural Health Association 21st Annual National Conference. Orlando, FL. For information, call (816) 756-3140 or fax (816) 756-3144. **May 13-16, 1998.**

American College of Sports Medicine Annual Meeting. Orlando, FL. For more information, call (317) 637-9200. **June 2-6, 1998.**

American Diabetes Association Annual Meeting. Chicago, IL. For more information, call (703) 299-2022. **June 11-16, 1998.**

National Wellness Institute Annual Meeting. Stevens Point, WI. For more information, call (715) 342-2969. **July 11-17, 1998.**

Online

Women's Health

Developed in conjunction with a special section June 22, 1997, in the *New York Times*, this site (http://www.nytimes.com/specials/women/whome/) offers articles on **29 women's health concernsa**, web versions of several recognized health books, an annotated guide of links, and a search engine.

The Women's Health component of the Global Health Network (http://www.pitt.edu/HOME/GHNet/GHWomen.html) provides links to hundreds of sites on **women's health issues worldwide**. Links include medical associations, research projects, consumer guides, government agencies, and databases. Topics cover general women's health, aging, cancer, domestic violence, heart disease, infectious diseases, maternal and child health, mental health, nutrition and fitness, and population and reproductive health issues.

In Print

Healthy People 2010

Developing Objectives for Healthy People 2010 is now available. This guide provides information on the process for developing the Nation's third set of disease prevention and health promotion objectives. It describes how individuals and organizations can get involved and provides background on the Healthy People initiative and a calendar of major milestones. $7 for a single copy; further discounts in quantities of 5 ($22), 10 ($35), 20 ($58), and 34 ($79) copies. Call (301)468–5960 to place your order. Supplies are limited.

Diabetes and Chronic Disabling Conditions

A new public service leaflet from the American Academy of Otolaryngology—Head and Neck Surgery offers advice on how to control tinnitus, which is constant ringing or "noise in the ears." ***Doctor, what causes tinnitus?*** outlines the causes of tinnitus and ways to cope with this disorder and lessen its severity and includes a list of "do's and don'ts" for those with the condition. For a free copy, send a self-addressed, stamped, business-size envelope to Tinnitus, c/o American Academy of Otolaryngology—Head and Neck Surgery, One Prince Street, Alexandria, VA 22314-3357.

Maternal and Infant Health

The Healthy Start Initiative: A Community-Driven Approach to Infant Mortality Reduction—Volume V: Collaboration with Managed Care Organizations will assist Healthy Start projects and their subcontracting service providers in developing proposals and entering into contracts with health maintenance organizations that serve Medicaid clients. The Healthy Start Initiative is a 6-year national demonstration program designed to reduce infant mortality and improve the health and well-being of women, infants, children, and families. Previous volumes in this series, which shares the lessons learned through the project, are ***Consortia Development; Early Implementation: Lessons Learned***;

Sustainability; and ***Community Outreach***. Single copies of each volume can be obtained at no charge from the National Maternal and Child Health Clearinghouse, 2070 Chain Bridge Road, Vienna, VA 22182-2536, or call (703)821-8955.

Mental Health and Mental Disorders

A clinical practice guideline, ***Recognition and Early Assessment of Alzheimer's Disease and Related Dementias***, helps clinicians identify changes in an individual that might be symptoms of Alzheimer's disease and other dementias. It also provides the tools needed to conduct an initial assessment when these changes or symptoms are present. Two related items, a quick reference guide for clinicians and a guide for patients and families, are available. For copies of the guideline, contact the Government Printing Office, (202) 512-1800. For copies of the quick reference and consumer guides, contact the Agency for Health Care Policy and Research Publications Clearinghouse at (800) 358-9295. To find all three Alzheimer's disease guideline documents online, go to **http://www.ahcpr.gov/guide/** and select "Clinical Practice Guidelines Online."

Tobacco

The new **Teen Smoking: Pack It Up!** curriculum helps educators and other youth workers build tobacco prevention programs. Ideal for nonsmokers in grades 7-12 and youth who have begun to experiment with tobacco but are not yet addicted to it, the curriculum also works as a motivating force to prepare already physically addicted youth to quit. The curriculum integrates content and skills-based learning in 18 activities and features a recipe format and reproducible handouts. Five posters for display in classrooms and other building locations reinforce the prevention message. For more information or to request a free 108-page catalog describing videos, posters, books, and other educational resources, write to The Bureau For At-Risk Youth, P.O. Box 760, Plainview, NY 11803-0760, or call (800)99-YOUTH.

Substance Abuse: Alcohol and Other Drugs

A new edition of *Straight Talk: Substance Abuse* is available. It is part of a substance abuse module that also includes a discussion leader's guide focusing on skill building. The entire module emphasizes and reinforces **drug-free values and behaviors** and deals with the negative consequences of substance abuse for the individual, family, and community. The special issue contains an interview with the director of the National Institute on Drug Abuse (NIDA) and a humorous resignation memo written by Joe Camel to his boss. The National Association of State Alcohol and Drug Abuse Directors and the National Prevention Network collaborated on the issue, with technical assistance from the Center for Substance Abuse Prevention, NIDA, and Join Together. Prevention specialists, Drug-Free Schools and Communities coordinators, health educators, counselors, and other youth-serving professionals may obtain a free copy by writing on their school or agency letterhead to The Learning Partnership, P.O. Box 199, Pleasantville, NY 10570, or by sending a fax to (914)769-5676.

ODPHP Publications Sale

Now you can order discounted copies of *Actual Causes of Death in the United States* (Inv. No. F0039), *For a Healthy Nation: Returns on Investment in Public Health* (Inv. No. M0016), and the fall 1996 edition of *Prevention Report*, which includes a list of web addresses for health information in the Healthy People 2000 priority areas (Inv. No. R0039). Bulk quantities are available in allotments of 10 ($5), 50 ($10), 100 ($15), and 500 ($25) copies for F0039 and R0039. Individual copies of

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Save the Dates!

The 1998 Partnerships for Networked Consumer Health Information Conferences are just around the corner—on April 28, 1998 in Washington, DC, and May 27–30 in Philadelphia, PA. A new conference web site will be open soon. For information on the previous conferences, visit http://odphp.osophs.dhhs.gov/confrnce/partnr97/.

Telehealth Benefits Available for Rural Health Care

Beginning January 1, 1998, about 12,000 public and not-for-profit rural health care providers will be eligible to receive lower cost telecommunications for clinical, nonclinical, informational, and educational services. Eligible providers include teaching hospitals, medical schools, schools of public health, community health centers, not-for-profit hospitals, mental health centers, migrant health centers, local health departments and agencies, rural health clinics, and consortia of these entities.

Current Regulations

The 1996 Telecommunications Reform Act requires that public and nonprofit health care providers have access to telecommunications services at rates comparable to those paid for similar services in urban areas. As part of a ruling by the Federal Communications Commission (FCC), subsidies will be paid to telecommunications providers to offset the added costs of service to rural areas. These subsidies, which can reach $400 million annually, will be offered on a first-come, first-served basis.

Telecommunications services in health care ("telehealth") have many uses, such as linking medical staff to their patients and professionals to their colleagues, providing continuing education, enhancing emergency notification, tracking emerging diseases, and allowing public health and medical practitioners to share information with the public or their patients. Examples of services that are eligible for benefits include:

- Education of the public and health care community about public health issues
- Collection and dissemination of public health data to appropriate government entities
- Coordination of the public response to disasters
- Prevention and control of disease
- Consultation between health professionals, such as primary care physicians and specialists
- Transmission of x-rays
- Remote diagnosis and monitoring of patients

The FCC will have application, instructional, and question-and-answer materials available in November 1997. For more information on the rural telehealth benefits and to obtain an application form, visit the FCC's telehealth web site at http://www.fcc.gov/healthnet, or call (888)CALL-FCC.

Information Sources

To promote the rural telehealth benefits, the U.S. Department of Health and Human Services (HHS) is developing an information package with its constituencies and partner organizations. In addition, various briefing sessions have been planned, such as an audio teleconference in November and a symposium in April 1998.

To obtain a copy of the HHS package or information about the briefing sessions, fax your request to (301)468-3028 or e-mail nhicinfo@health.org. You may also visit the Rural Information Center Health Service (RICHS) web site at http://www.nal.usda.gov/ric/richs/.

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M0016 are available for half price ($2.50). Call (301)468–5960. Supplies are limited.

On Video

Diabetes and Chronic Disabling Conditions

A new exercise videotape, *Pathways to Better Living with Arthritis and Related Conditions*, is divided into five parts that can be done separately to provide a variety of routines, or together for one complete workout. The video presents **breathing techniques, stretching exercises, an aerobic section, and a total body relaxation sequence**. The exercises can be performed seated, and no special equipment is needed. For more information, call the Arthritis Foundation at (800)207-8633 and ask for item #730-9050 ($29.95 plus shipping and handling). For a free brochure on exercise, write the Arthritis Foundation, P.O. Box 7669, Atlanta, GA 30357-0669.

In Funding

Environmental Health

The Arizona Department of Health Services (ADHS) will test children in central Phoenix for lead poisoning as part of a new 3-year project. The goals are to identify sick children and make sure they are helped and to **reduce the risk of lead poisoning** in the years ahead.

ADHS has been awarded a $350,000 grant from the Centers for Disease Control and Prevention for the first year of the project. Teams from the Maricopa County Department of Public Health Services will visit about 6,000 residences door-to-door in the target area and test an estimated 800 to 1,000 1- and 2-year-olds for elevated levels of lead. The target area is the 15-square-mile inner-city core with deteriorating older housing likely to contain lead-paint chips and dust. The county teams will leave educational materials at all homes in the area and will counsel families with children about lead poisoning risks. For children with elevated blood-lead levels, ADHS will investigate the causes and refer families to health care providers and to the City of Phoenix for lead-based-paint abatement and for application for lead-safe housing rentals.

Educational Aids

Heart Disease and Stroke

The free **Is It Time for a Heart to Heart?** kit is available to groups interested in educating older adults about congestive heart failure (CHF). The kit includes a leader's guide with instructions for conducting an educational program on CHF, a 15-minute video, easy-to-read consumer brochures, and an advertising poster. To order, contact Alliance for Aging Research, 2021 K Street, NW., Suite 305, Washington, DC 20006, or call (202)293-2856.

Physical Activity and Fitness

The Centers for Disease Control and Prevention has launched a new campaign to promote moderate physical activity among adults. The theme **"It's Everywhere You Go"** reinforces the fact that 30 minutes of moderate physical activity a day 5 or more days a week provide health benefits and fit easily into a normal daily routine. The campaign focuses on simple ways to add physical activity, such as taking the stairs instead of the elevator.

Developed for use by health professionals and community leaders, the campaign has sections on Marketing Strategies for Physical Activity, Working with the Media, and Developing Physical Activity Programs and Events. Other components of the kit include television messages featuring Olympic gold medal speed skater Dan Jansen, radio ads, a poster, and a print ad. For more information, contact the Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition and Physical Activity, MS K-46, 4770 Buford Highway, NE., Atlanta, GA 30341-3724, or call (888)CDC-4NRG or (888)CDC-4674 (toll free). To view the campaign materials online, go to **http://www.cdc.gov/nccdphp/dnpa/readyset/**.

New!

The Office of Disease Prevention and Health Promotion now has faxback service. Call (301)468-1204 for organizational referrals on a variety of health topics. Call (301)468-3028 for ODPHP Healthy People 2000 publications such as National Health Observances, Toll-Free Numbers for Health Information, and Healthy People 2000 Progress Reviews.

ETCETERA

The **U.S. Action Plan on Food Security** is scheduled to be released early in 1998. This action plan will be based on domestic and international discussion papers. The international discussion paper was released to the public in mid-October and is available on the Food Security home page (http://www.fas.usda.gov/icd/summit/summit.html). The paper includes input gained through a series of national consultations and public meetings held this past spring and summer. A workshop on the domestic paper is set for December 1997.

This activity follows up on the World Food Summit held in November 1996. The U.S. response to the summit is coordinated by a senior-level Interagency Working Group (IWG) that is co-chaired by the Departments of Agriculture (USDA) and State and the U.S. Agency for International Development. The IWG adopted the World Food Summit Plan of Action target of reducing the number of undernourished people by half no later than the year 2015. A subgroup, co-chaired by USDA and the Department of Health and Human Services (HHS), has been formed to focus on U.S. domestic food security and undernutrition issues.

USDA and HHS plan to establish a **Dietary Guidelines Advisory Committee** and invite nominations. The committee will determine if revisions of the 1995 Nutrition and Your Health: Dietary Guidelines for Americans is warranted based on thorough evaluation of recent scientific and applied literature. If so, the Committee will develop recommendations for these revisions.

Prospective members of the Committee should be knowledgeable of current scientific research in human nutrition and be respected and published experts in their fields. They should be familiar with the purpose and application of the Dietary Guidelines and have demonstrated interest in the public's health and well-being through their research and/or educational endeavors. Nominations should document the nominee's qualifications in the relevant subject areas.

More information is available from:

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