San Diego Surveyed For Heart-Healthy Foods and Exercise Facilities

Americans are being urged by scientific experts (*1–3*), voluntary health associations (*4,5*), and governmental agencies (*6,7*) to alter their dietary and exercise habits. Based on voluminous amounts of scientific research on the hazards of current American diets that are high in fat and sodium (*7,8*) and on inadequate physical activity practices (*9,10*), large-scale interventions are currently underway to alter the health behaviors of the population at large (*11*). Most of these interventions are designed to increase knowledge and motivation, to improve the ability to make more healthful decisions, and to implement them.

Many of the recommendations being made presuppose that alternative foods, such as low-fat dairy products and low-sodium snack foods are readily available to the consumer. Similarly, many activities that are recommended are aerobic exercises requiring facilities that can range from appropriate shoes and a safe place to walk to swimming pools and access to organized aerobic exercise classes.

Availability of "heart-healthy" foods and convenient access to resources that may be useful to exercisers are factors in the community environment which could either facilitate or constrain, and encourage or discourage, someone who is attempting to practice the recommended health behaviors.

To describe a method of assessing the availability of specified foods and physical activity resources in urban neighborhoods in relation to the socioeconomic characteristics of the neighborhood, a team from the University of California at San Diego conducted a pilot study in 24 neighborhoods in San Diego, CA. Neighborhood was defined as either the 1-mile radius around selected public elementary schools, or the neighborhood boundaries as defined by residents near the school who were interviewed. Health-related resources were assessed within this defined neighborhood.

Twelve of the schools were included in the San Diego Family Health Project (*12*), and they represented middle and lower income neighborhoods. The other 12 schools were chosen so that each socioeconomic status (SES) decile was equally represented. The family median income for 1979 for the 24 schools ranged from $4,059 to $21,049.

Neighborhood Surveys

The Neighborhood Health Resources Surveys were designed to allow direct observation of objective indicators of the availability of selected foods and physical activity resources.

The Physical Activity Resources Survey was based on a list of types of private and public facilities that might be available to someone attempting to obtain exercise. These included such public facilities as running tracks, parks, and recreation centers and private facilities like racquetball clubs, aerobics (or aerobic dance) studios, health spas, and YMCAs or YWCAs. There was also a list of the various kinds of stores selling sporting goods.

In the Food Availability Survey, stores were categorized as supermarket, neighborhood grocery, convenience store (such as 7-Eleven), or health food store. The survey form listed specific food items which were identified by a dietitian (JWR) as being lower in fat or sodium than the more traditional choice. Thus, 71 "heart-healthy" alternative foods were looked for by observers. Presence or absence of the item was recorded. To facilitate the food store inventory, the list was organized to reflect the layout of a typical food store. The list emphasized dairy products and packaged and processed foods, rather than fresh products, since the availability of fresh fruits and vegetables was so widespread in the area.

On the list were 20 dairy products such as ice milk, low fat cottage cheese, and unsalted margarine. Turkey, ham, and water packed tuna were representative of the seven meat products. The 11 grain products included puffed rice or corn and low-sodium potato or corn chips. Other items were low-sodium tomato juice, imitation mayonnaise, low-sodium mustard, low-sodium spice blends, old fashioned peanut butter, and vegetarian canned refried beans. The complete list is in table 1.

Procedure

Undergraduate student observers were trained in conducting the survey. They were instructed to drive to the identified school and systematically survey the neighborhood, as resident defined, up to a 1-mile radius. They were to inventory the stores following the survey layout. The observers were given a letter explaining the project to show the store manager. Only items with reduced sodium or fat clearly marked on the front of the package in bold print were counted.

When a physical activity resource was encountered, the name and address of the facility was recorded on the form. Observers were supervised weekly, and completed forms were checked. About half the neighborhoods were assessed by teams of two observers.

Reliability

Two neighborhoods were surveyed twice by different observers in order to calculate the reliability of the measures. Interobserver agreement (number of agreements divided by number of agreements plus number of disagreements) on individual food items was 99 percent for supermarkets and 78 percent for neighborhood markets. Interobserver agreement was 53 percent for physical activity resources. The total number of activity resources recorded by the two observers was relatively close (that is, 7 and 9 resources in neighborhood A; 7 and 10 in neighborhood B).

Physical Activity Resources

There was a mean of 7.9 (S.D. = 4.7, range 0 to 17) physical activity resources in each neighborhood. The most common resources are summarized in table 2. By definition, school playgrounds were common in these neighborhoods, but the availability of public parks was also extremely high. Seventy-eight percent of the neighborhoods were near more than one park. Other resources in most neighborhoods included sporting goods stores, department stores, and running tracks (usually at junior high or high schools).

Table 1. Targeted foods from food availability survey

Lowfat milk
Nonfat milk
Low sodium buttermilk
Lowfat yogurt
Nonfat yogurt
Mocha Mix liquid
Lowfat cottage cheese
Lowfat processed cheese (Weight Watcher's, Lite Line)
Lowfat cheeses
Low sodium cheese
Unsalted margarine
Lowfat margarine (liquid oil listed first)
Egg substitutes
Weight Watcher's frozen entrees
Lean Cuisine frozen entrees
Mocha Mix ice cream
Ice milk
Sherbet
Weight Watcher's frozen dessert
Lowfat frozen yogurt
Turkey ham
Turkey/chicken hot dogs
Packaged, pressed lean sandwich meat (Buddig, Donola)
Lowfat bacon (Sizzlean)
Canadian bacon
Water packed tuna
Low sodium tuna in water
Low sodium bread (check freezer)
Puffed rice or corn
Shredded wheat
Rolled oats (not instant)
Granola without coconut or palm oil
Low sodium granola
Low sodium crackers
Low sodium chips
Low sodium snack crackers
Low sodium pretzels
Low sodium canned vegetables
Low sodium tomato paste
Low sodium tomato sauce
Low sodium V8 juice
Low sodium tomato juice
Low sodium salad dressing
Low calorie salad dressing
Low sodium mayonnaise
Safflower oil mayonnaise
Imitation mayonnaise
Low sodium catsup
Low sodium mustard
Low sodium pickles
Low sodium relish
Low sodium chili
Low sodium spaghetti sauce
Salt substitute
Low sodium spice blends
Low sodium soups
Low sodium cookies
Unsalted nuts
Nuts in the shell
Low sodium peanut butter
Old fashioned peanut butter
Pam or other vegetable spray
Safflower oil
Corn oil
Sunflower oil
Nonfat dry milk
Vegetarian beans
Vegetarian refried beans
Dry pintos, other dried beans
Low sodium salsa
Low sodium soy sauce

Food Availability

The one neighborhood with no food stores was in an isolated, newly developed area; otherwise there were at least two food stores in each neighborhood. The number of food stores in the 24 neighborhoods was as follows:

Number of stores	*Percent of neighborhoods*
0	4
2	25
3	61
4 or more	11

A total of 77 stores were surveyed: 42 (55 percent) were supermarkets, 26 (34 percent) were neighborhood groceries ("mom and pop stores"), 6 (8 percent) were convenience stores, and 3 (4 percent) were health food stores. Since observers were instructed to survey the four largest stores in a neighborhood, these figures represent only a part of the actual number of stores available, and supermarkets are over-represented in the sample.

The mean number of targeted foods available in each type of store is presented in table 3. As expected, a greater selection of "heart-healthy" foods was found in supermarkets. The average supermarket had 57 of 71 targeted food items, and neighborhood groceries had more than a third of the target foods. Convenience stores offered very few low-sodium, low-fat foods. The health food stores surveyed had about the same number of alternative foods as neighborhood groceries. A one way analysis of variance revealed that the mean number of items available in supermarkets was significantly greater than in other types of stores. Size of the store correlated highly with the number of targeted foods available ($r = 0.82$, $P < .001$).

Food Activity Relationship

The relationship between the availability of food and physical activity resources was investigated by computing neighborhood scores for total number of food items available, total physical activity resources, and number of parks. Total available food items correlated 0.57 ($P < .002$) with physical activity resources. Number of parks was not related to either food or physical activity availability. Thus, the availability of low-fat, low-sodium foods and physical activity resources in neighborhoods are highly correlated, but the proximity of public parks is unrelated to either of the other two indices.

Table 2. Percent of 24 neighborhoods with physical activity resources nearby

Type of facility	*Percent of neighborhoods with at least one*
School playground	88
Public park	88
Sporting goods store	61
Department store (with sporting goods)	58
Running track	57
Bicycle store	46
Aerobics studio	43
Health spa	43
Recreation center	32
YMCA-YWCA	25
Racquetball club	25
Private tennis club	25
Dance club	25
Skating rink	18
Church playground	14
Beaches	11

Socioeconomic Status

Availability of physical activity resources was not related to socioeconomic status, but socioeconomic status was correlated in a nonlinear manner (Spearman correlations) with both total heart-healthy foods in neighborhoods ($r = .34$; $P < .05$) and mean heart-healthy foods at each store ($r = 51$; $P < .01$). Residents of

Table 3. Mean number of heart-healthy foods available, by type of store

Type of store	Mean	Standard deviation	Percent of 71 possible foods	Number of stores
Supermarket	56.7	9.9	78	42
Neighborhood grocery	25.7	9.7	35	26
Convenience store	12.2	5.4	16	6
Health food store	21.0	6.7	29	3

middle class neighborhoods generally had easier access to heart-healthy foods than those living in lower or upper class neighborhoods.

Discussion

The pilot study demonstrated that recommended foods and physical activity resources can be assessed and that availability differed by neighborhood. Problems with the measurement technique were also identified.

The reliability of the food store survey was adequate, providing support for the method. Reliability of the physical activity resource inventory was not acceptable. Several factors may account for the poor reliability. First, resident definition of the boundaries of the neighborhood led to imprecision. Second, having the elementary school as the focal point of the neighborhood was necessary to meet the goals of the study, but it was not an ideal method. Third, there was no standardized procedure for driving through the neighborhoods, so observers could easily miss some resources unless they drove down every block.

The almost universal convenience of public parks in these San Diego neighborhoods meant that space for family or group activities was available. Most neighborhoods had sporting goods stores and accessible running tracks, while many had bicycle shops and health spas. These data suggest that physical activity resources are widely available in San Diego, and access is not correlated with the socioeconomic status of the neighborhood. There were, however, important aspects of physical activity resources that were not measured in the pilot study, such as ease of riding bicycles in the neighborhood, safety factors (for example, crime rate), monetary cost of using facilities, and quality of facilities in parks. More refined measures taking these factors into account are needed.

The average supermarket surveyed stocked 78 percent of the foods listed. Thus, shoppers at large stores are assured access to a wide variety of low-sodium and low-fat food items. Those who shop at their local neighborhood grocery for miscellaneous items have very restricted choices of heart-healthy foods. Shopping regularly at small markets could be a significant barrier to following dietary advice (*4*). Shoppers at convenience stores find very few low-sodium and low-fat foods. Results of our surveys of three health food stores should be interpreted very cautiously, but at those stores relatively few processed foods low in fat and sodium were available.

This survey was limited by its focus on packaged foods. A shopper could buy primarily fresh foods, so the lack of availability of low-sodium and low-fat foods at some stores would not be a serious problem.

Virtually all neighborhoods had access to more than one food store, and most neighborhoods contained a supermarket. Socioeconomic rank was moderately correlated with availability of heart-healthy foods, and the probable reason for the finding is that middle class neighborhoods have more supermarkets. It is interesting that high socioeconomic neighborhoods had fewer total stores and less availability of heart-healthy foods than do middle status neighborhoods. This may be related to a lower population density of high socioeconomic areas.

Based on the results of this study, changes in the methodology can be suggested. Most importantly, clear geographic boundaries should be defined. The census tract maps would be an ideal method of obtaining standard geographical units about which much is known. More training should be given to observers, including guided practice in touring neighborhoods, identifying physical activity resources, and surveying food stores. Further development of the actual checklists is also recommended. The methods may have to be altered for use in other settings, especially rural areas. The survey could also be expanded to include assessment of the information environment (*13*).

Researchers are encouraged to study the effects of convenient health resources on actual health behavior, and this environmental assessment method is a tool to facilitate such research. The environmental influences on health habits are poorly understood, so the use of quantitative measures of selected environmental variables may produce significant new knowledge or eventually lead to new strategies for health promotion.

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Rand Report on Initiating Clinical Trials of Medical Practices Funded by NIH

The biomedical and research communities have long relied on randomized clinical trials (RCTs) for evaluating the safety and effectiveness of drugs, devices, and procedures for disease prevention, diagnosis, and treatment. However, little is known about the process leading to the initiation of RCTS—why they are done and how the topics are selected, for example. To meet this critical information need, the National Center for Health Services Research and Health Care Technology Assessment (NCHSR) awarded a contract to the Rand Corporation to identify the criteria governing the decision to support a clinical trial of a medical practice in current use.

The objective was to develop a model to guide policymakers in determining whether a medical practice should be subjected to a clinical trial, with the resulting large investment in time and resources. The focus of the Rand study was the decisionmaking process for initiating randomized clinical trials of current medical practices at the National Institutes of Health (NIH), the major sponsor of clinical trial research in the Federal Government. The study was based on a review of the research literature, four case studies of proposed clinical trials to be funded by NIH, and interviews with clinical trial investigators and employees involved in sponsoring clinical trials for their Institutes. The four case studies concerned clinical trials of extracranial-intracranial anastomosis, acute myocardial infarction, treatment of breast cancer, and intermittent positive pressure breathing.

According to the study, a three-stage process governs the decision to initiate an RCT of a current medical practice at NIH. The process both outlines present decisionmaking and provides a framework within which suggested improvements may be discussed. The three stages are awareness, relevance, and feasibility.

Awareness. Most current medical practices are accepted without serious question. However, some have come to be used without any thorough evaluation of their safety, effectiveness, benefits, and costs. Such evaluations do not occur until there is awareness that the appropriateness of those practices is being questioned. Awareness can arise through a common belief that the value of a particular practice is unknown, or more typically, through a difference of opinion among investigators and clinicians about the practice's safety or efficacy.

Relevance. There is a winnowing of many possible candidates for RCTs on the basis of their perceived relevance to a critical medical problem. The process hinges substantially on the importance of the problem to be addressed: the more people that are affected, the more dire the disease, and the more expensive the treatment, the more relevant the proposed RCT. The perceived need for a proposed RCT is heightened by the absence of alternative research strategies to address the problem.

Feasibility. Although there may be a consensus that the RCT is the most appropriate way to perform the investigation, a number of feasibility constraints may prevent the RCT from being done. These constraints are a mixture of technical, philosophical, and policy barriers. High methodological and ethical standards for clinical research make it difficult to implement even highly relevant proposed RCTs. Moreover, even the best-designed trial must be deemed appropriate to the mission of a sponsor.

The Rand investigators also identified issues of interest to policymakers concerning the RCT decisionmaking process. For example, findings suggest that there is no uniform process at NIH for deciding whether to initiate RCTs. Each Institute's procedure is guided according to its programmatic interests, budgets, preferences for interacting with investigators, and the means employed to keep aware of the medical research needs of the public. All of these differences result in varied processes for the individual Institutes. But because the Institutes have distinct missions and focus on diverse medical problems, these differences are neither surprising nor inappropriate. In most cases, NIH institutional policy is an appropriate adaptation to its environment.

Candidates for RCTs come to official awareness largely in a nonsystematic manner. In addition, there is no adequate system for NIH or other sponsoring agencies to identify questionable medical practices as possible RCT topics. Finally, the study found no clear mandate for the sponsorship of clinical trials dealing with cost effectiveness issues. No one Federal agency is specifically directed to evaluate cost-effectiveness of current practices, and the appropriate source of that support is unclear.

Rand report R–3289–NCHSR, "The Decision to Initiate Clinical Trials of Current Medical Practices," by James P. Kahan, C. R. Neu, Glenn T. Hammons, and Bruce J. Hillman, may be ordered for $7.50 from the Rand Corporation, P. O. Box 2138, 1700 Main St., Santa Monica, CA 90406–2138. Appendices detailing the case studies of proposed RCTs also are available for $4 each: "Initiating Clinical Trials: A Case Study of Extracranial-Intracranial Anastomosis," N–2320/1–NCHSR; "Initiating Clinical Trials: A Case Study of a Proposed Clinical Trial for Acute Myocardial Infarction," N–2320/2–NCHSR; "Initiating Clinical Trials: A Case Study of Treatment of Breast Cancer," N–2320/3–NCHSR; and "Initiating Clinical Trials: A Case of Intermittent Positive Pressure Breathing," N–2320/4–NCHSR.

Gains on the Road to 1990 Health Goals Documented in Latest Prevention Report

"As a Nation, we have moved within striking distance of our 1990 goal of reduced mortality and morbidity at every life stage." This prefatory statement by Margaret Heckler, former Secretary of Health and Human Services, sums up the content of "Prevention '84/'85," the third in a series of biennial documents summarizing Federal prevention efforts.

The 166-page publication consists of four chapters. Chapter 1 features a

closeup look at the environmental areas of health protection encompassing toxic agent and radiation control, occupational safety and health, accident prevention and injury control, fluoridation and dental health, and surveillance and control of infectious diseases. Chapter 2 presents 28 charts that track a variety of health status trends for people at each of five major stages of life.

"Agency Innovations," Chapter 3, gives the agency-by-agency details of activities that comprise the Department of Health and Human Service's contributions to prevention as well as those of other Federal agencies. Chapter 4 is a comprehensive inventory of the dollar resources devoted by the various agencies of the Department to the 15 priority areas of the 1990 objectives. The total, not including block grants, was $3,823,993,132 in fiscal year 1984.

Single copies of "Prevention '84/'85" can be obtained free from the National Health Information Clearinghouse, whose tollfree number is 800–336–4797 (in Virginia 703–522–2590) or write Clearinghouse, P. O. Box 1133, Washington, DC 20013–1133. If writing, please enclose a self-addressed mailing label to expedite handling of the order.

Perinatal AIDS Guidelines Recommend Counseling, Antibody Testing

In guidelines on the prevention of perinatal transmission of AIDS, the Public Health Service recommends counseling, and HTLV–III/LAV antibody testing when indicated, for women who are at increased risk of acquiring the AIDS virus and are either pregnant or considering pregnancy (*1*).

The PHS guidelines were issued to assist health care providers and State and local health departments in developing procedures for preventing the perinatal transmission of HTLV–III/LAV, the virus that causes AIDS. The recommendations are the latest in a series of PHS guidelines dealing with AIDS.

"It is important that infected and potentially infected women know the risks associated with pregnancy and know and understand their HTLV–III/LAV status," said Donald R. Hopkins, MD, Deputy Director, Centers for Disease Control, in issuing the recommendations.

"Through counseling, uninfected women can learn how to avoid becoming infected and infected women can choose to delay pregnancy until more is known about the perinatal transmission of AIDS. Infected women who are already pregnant can be given information that will help them and their health care providers in the clinical management of the pregnancy and the newborn."

Although the recommendations concern women, men found to be HTLV–III/LAV antibody positive should also be counseled about the risks of sexual and perinatal transmission and the need to refer sexual partners who are pregnant, or are considering pregnancy, for counseling and testing.

Perinatal risks. Of the 15,172 AIDS cases reported to the Centers for Disease Control as of December 1, 1985, 217 cases were in children under 13 years old, and 61 percent of the children had died. The total number of children with illnesses resulting from HTLV–III/LAV infection is greater, however, because less severe manifestations, often referred to as AIDS-related complex, are not reported to CDC.

Of the 217 pediatric cases, 76 percent have as their only known risk factor a mother in a group with increased prevalence of HTLV–III/LAV infection. Forty-eight percent of the children had mothers who were intravenous (IV) drug abusers, 17 percent had mothers born in Haiti, and 10 percent had mothers who were sex partners of either IV drug abusers or bisexual men.

It is believed that the AIDS virus is transmitted from infected women to their fetuses or offspring during pregnancy, during labor and delivery, or perhaps shortly after birth. Transmission of the virus during pregnancy or labor and delivery has been demonstrated by two cases of AIDS reported in children who had no contact with their infected mothers after birth. Transmission of the virus after birth is shown by a case of HTLV–III/LAV infection in an infant whose mother reportedly acquired the virus from a postpartum blood transfusion and breast-fed her infant for 6 weeks. The virus has recently been isolated from the breast milk of infected women.

The rate of perinatal transmission of the virus from infected pregnant women is unknown. Limited available data suggest a high rate of transmission—65 percent in one study of women who had already delivered one infant with AIDS. Perinatal transmission from an infected mother to her newborn is not inevitable; other studies show lower rates of transmission.

Besides the risk of transmission to infants of infected mothers, there is also concern for infected mothers. During pregnancy there is some suppression of immune system function and increased susceptibility to some infections. It is possible, but not proven, that pregnancy may place an asymptomatic HTLV–III/LAV-infected woman at increased risk of developing AIDS or AIDS-related complex, and at least one study suggests that this may be the case. Of 15 infected women who were well at the time of delivery and then followed an average of 30 months, 5 women (33 percent) subsequently developed AIDS, 7 (47 percent) developed AIDS-related conditions, and only 3 (20 percent) remained asymptomatic.

Recommendations. The PHS guidelines recommend that counseling services and voluntary antibody testing be offered to pregnant women and to women who may become pregnant in the following groups:

- Women with evidence of HTLV–III/LAV infection;
- Women who have used drugs intravenously for nonmedical purposes;
- Women born in countries where heterosexual transmission is thought to play an important role in spread of the virus;
- Women engaged in prostitution; and
- Women who are or have been sex partners of IV drug abusers, bisexual men, men with hemophilia, men born in the countries cited previously, or men who otherwise have evidence of HTLV–III/LAV infection.

Routine counseling and testing of women who are not members of these high-risk groups is not recommended; however, if a woman requests these services, they should be provided.

Provision of counseling and antibody testing is recommended in any medical setting where women at increased risk are commonly encountered, such as detoxification and methadone main-

tenance clinics, comprehensive hemophilia treatment centers, sexually transmissible disease clinics, and clinics that serve female prostitutes. In addition, facilities offering family planning and infertility services; gynecological, premarital, or prepregnancy examinations; and prenatal and obstetrical services should consider offering counseling and testing if clients include high-risk women.

Antibody testing should be performed with the woman's consent, after counseling that describes risk factors for infection, risks of transmission, possible adverse effects of the immune suppression of pregnancy in infected women, and proper interpretation of antibody test results. Counseling and testing must be conducted in an environment where confidentiality can be assured. If this cannot be done, referrals should be made to appropriate facilities.

The fact that detectable antibodies to the virus may not develop until 2–4 months after exposure and whether the woman is continuously exposed should be taken into account when considering the need for, and frequency of, repeat testing. High-risk women should be offered counseling and testing before they become pregnant. During pregnancy, counseling and testing should be offered as soon as the woman is known to be pregnant. If the initial test is negative, repeat testing may be indicated near delivery to aid in the clinical management of the pregnancy and of the newborn. If this final test is negative and the mother's risk of exposure no longer exists, she may safely consider breastfeeding the child, and management of the child need not include the same concerns that would be appropriate if the woman had had a positive test or if she were at high risk and had not been tested at all.

Recommendations for counseling women according to the results of antibody tests are given in detail in the PHS guidelines, which were published in the December 6, 1985, Morbidity and Mortality Weekly Report (*1*).

Health care providers, social service personnel, and others who care for persons infected with the AIDS virus should be aware of the potential for social isolation if the person's condition becomes known, and they should be sensitive to the need for confidentiality. These workers should be familiar with Federal and State laws, regulations, and policies that protect the confidentiality of clinical data and test results. In addition, each institution should ensure that mechanisms are in place to protect the confidentiality of all records and to prevent misuse of information. Anonymous testing would not be appropriate if it prevents adequate counseling and medical followup evaluation.

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Uniform Aspirin Labeling Regulations Proposed for Reye Syndrome Alert

A proposed regulation, published by the Food and Drug Administration, mandates labeling of aspirin-containing nonprescription products to alert consumers to a possible link between aspirin use in children and teenagers with flu or chicken pox and the development of Reye syndrome.

Reye syndrome, which generally follows flu or chicken pox, is rare, but death results in 20–30 percent of the cases. Permanent brain damage occurs in some survivors. The condition is marked by severe tiredness, belligerence, or excessive vomiting.

The new label would be the first warning listed on packages of aspirin and aspirin-containing products. The label would say:

"WARNING: Children and teenagers should not use this medicine for chicken pox or flu symptoms before a doctor is consulted about Reye syndrome, a rare but serious disease."

The proposed regulation follows voluntary action by aspirin manufacturers to alert consumers. All aspirin produced by manufacturers who are members of the Aspirin Foundation of America carried Reye-related label warnings by August 31, 1985, and other aspirin makers also participated in the voluntary program. By the first week of November, 68 percent of children's aspirin found on store shelves carried a voluntary warning. Data for December were expected to show another sizable increase in the relabeled products on retail shelves.

However, the voluntary warning statements vary, and some companies that are not members of the Aspirin Foundation of America have not included any warning at all. Still other labeling does not specifically mention Reye syndrome as a possible consequence of giving aspirin for flu or chicken pox. Because of these reasons, a majority of aspirin manufacturers support the mandatory labeling requirement.

After comments on the proposal are considered and the rule is finalized, aspirin manufacturers will have 90 days to comply with the regulation. The FDA is hoping to finalize the regulation by springtime.

The labeling regulation is an interim measure that will be reviewed and possibly revised as soon as the Public Health Service completes a full-scale epidemiologic study.

UNC Expands MPH Training for Native American Students

The School of Public Health at the University of North Carolina at Chapel Hill will expand its nonresidential master of public health program in 1986 to include Indian employees of the Indian Health Service (IHS).

The school has offered a nonresidential MPH program since 1969, and since 1979 has housed the MPH Program for American Indians.

The Indian program is similar to those provided by the University of Hawaii, University of California at Berkeley, and the University of Oklahoma. They emphasize the recruitment, academic training, and support of Native Americans in various public health disciplines. The program at UNC–CH distinguishes itself from these programs by providing, in addition to the above, the only accredited nonresidential MPH degree program which specifically serves the manpower development and training needs of the Indian Health Service.

The nonresidential degree program is seeking to enroll 8 to 10 IHS Indian employees each year. These employees, who will be identified and sponsored by the IHS, will be required to meet all the admission requirements of the UNC–CH Graduate School and its Department of Health Policy and Administration. Those requirements include

- a bachelor's degree and 3 years' experience in health administration or

a health profession, or an academic or professional doctoral degree in an appropriate field;
- a minimum grade point average of 3.0 on a 4.0 scale;
- employment in a full-time managerial or clinical position throughout the term of study;
- a minimum graduate record examination score of 1,000 or an acceptable score on an equivalent examination.

The 3-years experience and managerial position requirements may be waived on a case-by-case basis for IHS Indian employees. This provision is designed to provide greater access to the program for younger employees whom IHS may wish to advance.

A total of 39 semester hours of study will be required for the MPH degree. Up to 12 hours may be transferred from other graduate programs, subject to departmental approval. Of the 39 hours, 15 may be taken in an "integrated" course format, each entailing a 2 1/2-day introductory classroom seminar, followed by 14 weeks of home study of specially prepared material under the direction of course instructors. Each integrated course will conclude with a 2 1/2-day intensive review and final examination in the classroom at UNC–CH. Integrated courses are offered during the fall and spring semesters. The remainder of the course work is taken during regular summer sessions in Chapel Hill.

A research-based report of master's thesis quality is required, except that students may opt for a special 3-credit course on health service research instead. The alternative course has significant writing requirements.

Support activities for students will include the use of a specialized academic skills guide, summer workshops, and a special pre-orientation program to assist students in their adjustment socially and academically.

Classroom sessions will be limited to 6-week summer institutes and 1 week in January.

—DAVID McCOY, JD, MPH, MEd, Director, Program for American Indians, Office of the Dean, and MOSES CAREY, Jr., JD, MSPH, Clinical Assistant Professor and Director, Office of Nonresidential Programs, Department of Health Policy and Administration, both at the School of Public Health, University of North Carolina at Chapel Hill.

Ohio Achieves 1990 STD Education Objective

Ohio has already achieved the national 1990 Health Objective for Sexually Transmitted Disease Education with a program that reaches every junior and senior high school student in the State.

Called the "Ohio Plan," the program accomplishes teacher training with a publication entitled, "Educator's Guide to Sexually Transmitted Diseases," which was put together jointly by inner-city teachers, students, and disease intervention specialists.

The cost of the plan has been estimated at 7 cents per student. Two other States have adopted the Ohio Plan to their use.

Further information may be obtained from Dr. Stephen R. Sroka, 1284 Manor Park, Lakewood, OH 44107.

AAPHD Seeks Public Health Dentistry Papers for Meeting

The American Association of Public Health Dentistry (AAPHD) is inviting papers on a broad range of dental public health subjects for its 49th annual meeting to be held in Miami, FL, October 16–18, 1986. Abstract deadline is April 1, 1986.

Papers are solicited on a broad range of topics, including

School health; dental care delivery systems; oral epidemiology; asepsis and infection control; occupational health in dentistry; dental education; access to care; quality assessment; quality assurance; cost containment; program evaluation; dental disease prevention; dental insurance; dental practice acts; computers and management of data; fluoridation; cariology; preventive periodontics; Federal, State, and local dental programs; auxiliary utilization; geriatric dentistry; hospital and institutional dental services; health education; dental manpower; alternative dental personnel; health promotion; community organization; health policy; health litigation; and related topics.

Abstracts will be selected by a blind review process and will be rated on originality, significance, and quality of supporting data. They should be 200 words or less, typed single space on the lower half of an 8 1/2 x 11 sheet of paper, and identified by name, address, and phone number of author. Three copies should be submitted to Michael W. Easley, DDS, MPH, FACD, Vice President and Program Chairman, AAPHD, c/o American Oral Health Institute, Inc., P. O. Box 151528, Columbus, OH 43215–8528.

Animal-People Conference Scheduled for Boston

An international conference, "Living Together: People, Animals, and the Environment," will be held August 20–23, 1986, in Boston, MA.

The sponsoring Delta Society of Renton, WA, calls it the most comprehensive interdisciplinary conference to date in the field of human-animal interaction. Scientists, academicians, and community program leaders will be sharing research, workshops, and scholarly papers.

The range of topics to be presented includes animals and the elderly, animal-facilitated therapy, human-animal ecology, animals in research, animal abuse, animals in literature.

Additional information may be obtained from the Delta Society, 212 Wells Ave. South, Suite C, Renton, WA 98055–2130.

Hopkins Gets $4.7 Million A.I.D. Grant for Child Survival Programs in the Third World

The U.S. Agency for International Development (A.I.D.) has awarded a 5-year, $4.7 million grant to the Institute for International Programs of the Johns Hopkins School of Hygiene and Public Health to develop child survival programs. The Institute develops and tests vaccines, provides training in international health, and evaluates programs in developing countries.

Although public interest has focused on famine in African countries, the problems of child survival are broader. Almost 25 percent of the children in developing countries—10 million—die of preventable respiratory and diarrheal diseases and malnutrition before they reach the age of 5, according to W. Henry Mosley, MD, Director of the Institute and Chairman of Population Dynamics at Hopkins.

The funding for the period 1985–90 will allow the Institute to take the initiative in collaborating with develop-

ing countries to provide needed research, training, and program development, D. A. Henderson, MD, MPH, dean of the school, pointed out.

Disease rates are high in developing countries because proper immunization for diseases such as tetanus, diphtheria, poliomyelitis, measles, and whooping cough is rare. For example, more than 90 percent of the preschool children in the United States receive poliomyelitis vaccine. Yet fewer than 20 percent of the same age group are vaccinated in developing countries, where the disease strikes more than 5 in 1,000.

Noting that health workers have great difficulty making certain that children in developing countries receive proper vaccines, Mosley declared that better immunization could be achieved through new vaccination methods that would replace repeated trips to medical clinics for booster shots. Immunization of mothers during pregnancy could save more than 800,000 infants who die from tetanus contracted when their umbilical cords are cut with dirty or crude devices and cow dung, ashes, or dirt is used to stop the bleeding, he added.

In Kenya, the Institute's investigators will examine the levels of immunity in children whose mothers were given vaccines for tetanus, diphtheria, and poliomyelitis during pregnancy. If the children develop immunity before birth, they will need only a booster injection at birth to continue protection through their earlier years.

In another Institute project, researchers will examine the effectiveness of giving measles vaccinations to sick children in Haiti. In many developing countries, children are sick half of their childhood, when most vaccines must be given, but physicians have been reluctant to given children vaccines for safety reasons. If the sick children can be safely and effectively immunized, vaccinations could be given routinely at medical clinics.

The grant also supports activities directed at the special needs of children and mothers, such as oral rehydration to combat diarrheal diseases, education groups in nutrition and sanitation, and promotion of the spacing of births.

Evidence from earlier studies in Indonesia by Alfred Sommer, MD, Professor of Ophthalmology and International Health, indicates that diet supplements of vitamin A may help reduce diarrheal and respiratory diseases. Kenneth Brown, MD, Assistant Professor of Pediatrics and International Health from the Institute will examine how well vitamin A helps prevent infant and child deaths in the Philippines and Peru.

Also, the Institute will create an international health fellowship program that will allow American graduate students or postgraduate fellows to train with A.I.D., either in Washington or overseas.

The effectiveness of programs in reducing rates of illness and death in several countries will be studied by Hopkins faculty. Under the guidance of Ronald Gray, MBBS, Professor of Population Dynamics, the investigators plan to examine the health impact of services, staff training, distribution of supplies and health education and information as well as the cultural acceptability and effectiveness of promoting home hygiene and sanitary food handling in Ecuador, Haiti, and the Philippines.

U.S. Hospital Employment Steady, Long-Term Psychiatric Jobs Down

Hospital employment in the United States was stable overall between 1981 and 1983 even though there was a decline in long-term psychiatric institutions jobs.

Total full-time equivalent employment in all hospitals rose from 3,690,556 in 1981 to 3,736,744 in 1983, according to "Trends in Hospital Personnel 1981–83: From the American Hospital Association Annual Surveys," published by the Public Health Service's Health Resources and Services Administration (HRSA).

The long-term psychiatric decline occurred for both patients and employees, while the trend was upward for administrators, registered nurses, medical record personnel, pharmacists, occupational and physical therapists, and social workers at short-term community hospitals. The trend was down for dietitians and licensed practical nurses.

"Trends in Hospital Personnel 1981–83: From the American Hospital Association Annual Surveys" can be purchased for $22.95 plus a $3 handling charge from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161 (telephone 703: 487–4600). When ordering, specify HRP–0906595.

New Drug Approval Record Set in 1985 by FDA: Bowen

The Food and Drug Administration approved a record number of totally new drugs in 1985.

A total of 30 new drugs, chemically different from any previously approved by FDA, were given approval last year. This represented eight more approvals than in 1984 and the largest number of such approvals since legislation in 1962 required drugs to be reviewed for effectiveness as well as general safety.

"Out of the hundreds of drug approvals of different kinds given by FDA each year, these approvals for new chemical entitites are especially significant," HHS Secretary Otis R. Bowen, MD, said in making the announcement. "These are totally new drugs, the breakthrough products which can mean new therapies and new health opportunities for Americans."

Dr. Bowen said the record number of approvals for new chemical entities "shows the results of vigorous and productive research by our pharmaceutical industry as well as improved cooperation between government and the private sector under the Reagan Administration. And the American consumer is the beneficiary."

New chemical entity approvals in recent years have totaled 22 in 1984, 14 in 1983, 28 in 1982, 27 in 1981, and 12 in 1980.

FDA Commissioner Frank E. Young, MD, said that new chemical entities "are often the most difficult to assess—but in addition, they are frequently among the most promising drugs."

For example, one new chemical entity approved in 1985 was Protropin, the first genetically engineered human growth hormone and only the second genetically engineered drug approved by the agency. (The first was human insulin, approved in 1982.) Human growth hormone permits children with pituitary deficiencies to grow to near-normal height.

Other approvals included Seldane, the first antihistamine considered effective without the associated undesirable side effects of sleepiness and reduced mental alertness; Ridaura, the first gold-containing drug for rheuma-

toid arthritis that has proven effective in an oral dose; and Marinol, or THC, for treatment of severe nausea and vomiting associated with cancer chemotherapy.

In addition to approvals for new chemical entities, a larger number of FDA approvals are given each year for new dosage forms, strengths or formulations of previously approved chemicals.

Foundation Issues Report on States and 1990 Objectives

The Public Health Foundation has issued a report, "Profile of 1983 State Health Agency Data Relevant to the 1990 Objectives for the Nation."

The 121-page report provides a summary of information reported by State health agencies, referenced material for the specific 1990 objectives, and State-specific data and tables.

Areas covered include high blood pressure control; pregnancy and infant health; sexually transmitted diseases; occupational health and safety; misuse of alcohol and drugs; family planning; immunizations; toxic agent control; fluoridation and dental health; nutrition; and surveillance and control of infectious diseases.

Copies of the report are available for $10 each from the Public Health Foundation, 1220 L Street, N.W., Suite 350, Washington, DC 20005.

1985 National Drug Code Directory Published by FDA

For the first time, National Drug Approval (NDA) numbers (in most instances) will be shown in the 1985 edition of the National Drug Code Directory published by the Food and Drug Administration.

The directory, which contains the only complete list of prescription drug products marketed in the United States, is useful to the drug and health care industries; third party reimbursement insurance groups; local, State, and Federal government agencies; and the private sector.

The last edition of the directory was published in 1982.

Price of the directory includes two years of quarterly update supplements.

National Drug Code Directory. Copies may be purchased from the Superintendent of Documents, Subscription Entry, U.S. Government Printing Office, Washington, DC 20402. GPO stock number: 917-009-00000-7. Price: $76 (domestic), $95 (foreign).

Approved Uses of Radiation in Food Broadened by FDA's New Rule

Approved uses of radiation in food will be broadened under a final rule of the Food and Drug Administration. The regulation will be published in the Federal Register following review by the Office of Management and Budget.

Treatment of fruits and vegetables with picowaves may make some foods more available or less expensive. Unlike chemical pesticides, some of which are now under attack, irradiation leaves no residue in food. It does not make food radioactive, nor does it pose any radioactivity danger to the consumer.

The FDA's regulation will permit the following:

- fresh fruits and vegetables to be picowaved at up to 1 kiloGray to kill anthropod pests and to inhibit spoilage;
- dry or dehydrated vegetable substances (herbs and spices) to receive up to 30 kiloGray to kill insects and bacteria. The limit for use has been 10 kiloGray.

(Gray, the international unit for expressing the amount of energy absorbed from irradiation, replaces the rad unit. One Gray equals 100 rad.)

Under the regulation, manufacturers, food processors, and food retailers must label fresh fruit and vegetables which have been exposed to picowaves. At the retail level, signs may be placed over bins or on boxes if the items are displayed in the box, or items may be individually labeled. All retail level labels will include the international logo first used in the Netherlands (see left). In addition, retail level labeling or displays must carry the statement "PICOWAVED," and may include the reason, such as "PICOWAVED TO CONTROL SPOILAGE" or "PICOWAVED TO EXTEND SHELF LIFE."

Approval of the regulation will expand the uses of low-level radiation already allowed by the Food and Drug Administration. The process has been approved for use in the United States for two decades to kill insects in wheat and to slow the development of sprouts in potatoes. In addition, the use of radiation was approved in 1983 for herbs and spices and in July 1985 for pork.

FDA Commissioner Frank E. Young, MD, commented, "In all, the United States and 20 other countries allow the use of picowaves on foods."

The process is expected to lead to the reduced use of pesticides on foods. The amount of ionizing energy permitted under the regulation is well within the bounds of safety for human consumption. Nutritional values are not significantly changed by the radiation.

Johnson, HUD Launch Program for Mentally Ill in Eight Large Cities

The Robert Wood Johnson Foundation and the U.S. Department of Housing and Urban Development (HUD) will be funding a major new initiative to improve the delivery of services to the chronically mentally ill in 8 of the nation's 60 largest cities.

The cities are eligible to apply under the Program for the Chronically Mentally Ill, a unique public-private partnership which is co-sponsored by the U.S. Conference of Mayors, the National Governors' Association, and the National Association of Counties.

The Foundation will provide approximately $28 million in grants and loans over 5 years to support the development of city-wide mental health authorities that offer a range of community programs and supervised housing. Funds could total $3.5 million per city.

Grantee cities with approved housing plans will also be eligible for Federal rent subsidy assistance from HUD, which has authority to provide assistance over a 15-year period that could add up to $75 million.

Low-interest loans from the foundation of up to $1 million for each city will be available to grantees to acquire and renovate housing for the chronically mentally ill. This money will leverage other support in the form of grants, loans, bonds, and other government and private assistance.

The number of patients residing in public mental hospitals has decreased from a high of about 560,000 in 1955 to approximately 120,000 inpatients today—a decrease of 75 percent, a foundation spokesman said. The total number of seriously disabled chronically mentally ill is thought to have increased, accompanying the growth of the U.S. population, from an estimated 1.5 million in 1955 to 2.4 million today.

Cities face special challenges in developing effective community-based services for the mentally ill who are often inadequately housed or homeless. And many of the mentally ill have never participated in community care and rehabilitation programs and, as a result, are frequently admitted and readmitted to public hospital psychiatric units and public mental hospitals. Many have limited or no health insurance coverage.

Examples of services that might be initiated or expanded under the new program include residential facilities with varying levels of treatment and supervision, day rehabilitation programs, day hospitals, sheltered work programs, supervised transitional employment, and outreach for locating and assisting the homeless mentally ill. These might be incorporated into such new systems as public corporations and other public-private arrangements.

The Program for the Chronically Mentally Ill is being administered by Miles F. Shore, MD, Bullard Professor of Psychiatry at the Harvard Medical School, Area Director and Superintendent of the Massachusetts Mental Health Center of the Massachusetts Department of Mental Health in Boston, and Senior Program Consultant to the Robert Wood Johnson Foundation.

To be eligible, applicants must be nonprofit organizations or public agencies which are designated as the single mental health authority responsible for the community's chronically mentally ill. They must obtain the endorsement of the public housing authority, the mayor of their city, their county elected officials, their governor, and the mental health commissioner of their State.

Deadline for applications is May 15, 1986. Grants will be announced by November 1, 1986.

The eligible cities include

New York and Buffalo; Los Angeles, San Diego, San Francisco, San Jose, Long Beach, Oakland, Sacramento, and Fresno; Chicago; Houston, Dallas, San Antonio, El Paso, Fort Worth, Austin, and Corpus Christi; Philadelphia and Pittsburgh; Detroit; Phoenix and Tucson; Honolulu; Baltimore; Indianapolis.

Memphis and Nashville-Davidson; Washington; Milwaukee; Jacksonville, Miami, and Tampa; Boston; Columbus, Cleveland, Cincinnati, and Toledo; New Orleans and Baton Rouge; Denver; Seattle; Oklahoma City and Tulsa; Kansas City and St. Louis; San Juan; Atlanta; Portland; Minneapolis and St. Paul; Albuquerque; Omaha; Charlotte; Newark; Virginia Beach and Norfolk; Louisville; Wichita; Birmingham.

Medically Indigent Problem Subject of New Report

An overview of the medically indigent problem, including its causes and a description of the indigents' characteristics is contained in a new report on the problem by the Intergovernmental Health Policy Project of the George Washington University.

The report profiles each State's indigent care program, describing eligibility standards, administrative responsibilities, benefit coverage, source of funding, recipient counts, and total expenditures.

Copies of "State Programs of Assistance for the Medically Indigent" may be obtained for $20 each plus $2 for handling from the Intergovernmental Health Policy Project, 2100 Pennsylvania Ave., N. W., Washington, DC 20037.

Erratum: Malpractice Forum Proceedings

An incorrect address was listed in the November-December 1985 issue of *Public Health Reports* as the source for the proceedings of the Forum on Malpractice Issues in Childbirth:1985. The proceedings can be ordered from Director of Publications, International Childbirth Education Association, P.O. Box 20048, Minneapolis, MN 55420-0048. Price per copy $8.