

OMCH Promotes Breastfeeding through Grants to 16 Varied Projects

For more than 50 years, the Federal Government has been active in advancing infant nutrition, including breastfeeding. In the mid-forties, the Children's Bureau of the Public Health Service (PHS) joined with the American Academy of Pediatrics to conduct the first national survey of the incidence of breastfeeding in American hospitals. In 1966 the Children's Bureau supported a study of the costs of meeting the nutritional needs of infants. Throughout the years, educational materials advocating breastfeeding were prepared for prospective parents, and in 1980 a quantifiable objective for breastfeeding was established by the PHS. That year, in "Promoting Health, Preventing Disease—Objectives for the Nation" it was stated that "by 1990 the percentage of women who breastfeed their babies should be increased to 75% at hospital discharge and to 35% at 6 months of age." To facilitate progress toward achieving this objective, the 1984 "Surgeon General's Workshop on Breastfeeding and Human Lactation" developed strategies and recommendations which were published in the report of this workshop. Two years later the followup report was published to document efforts to implement workshop recommendations.

The PHS's Office of Maternal and Child Health has had a lead role in these efforts and has also supported various breastfeeding activities in the areas of promotion, training, and research. Elizabeth Brannon, clinical nutrition specialist, is responsible for coordinating the breastfeeding activities. A listing of the current projects, a brief description of their foci and materials produced, and identification of a contact person follow. People interested in conducting similar breastfeeding activities may contact the grantees for information that can be used in their States, counties, or communities.

Promotion

Promoting Breastfeeding at the Worksite and in the Neighborhood—National Child Nutrition Project. This project is targeted toward low-income working women. Activities include edu-

cational materials for pregnant and breastfeeding women that focus on general breastfeeding and breastfeeding and working, support networks centered around peer counselors, training materials for community women who serve as counselors, and educational sessions on working and parenting issues for community groups and labor unions which have resulted in the formation of parent advocacy groups for worksite changes to facilitate breastfeeding for working women.

Contact: Lynne Corboy, MS, Project Coordinator, National Child Nutrition Project, 1501 Cherry St., Philadelphia, PA 19102 (215: 496-9003)

Washington State/Seattle-King County Breastfeeding Promotion Project.

This project is a model for integrating breastfeeding promotion into an existing health care service delivery system. Of two project sites selected, one has a high percentage of very low-income minority clients; the other, a more homogenous low-income Caucasian population. Activities include staff education, networking with hospitals where project clients deliver, development of print materials and a promotional videotape for target clients, a triage tool, and two statewide training programs for professionals. Clinical activities include prenatal counseling, prenatal breastfeeding classes, postpartum phone contacts, and postpartum and well child office visits and home visits.

Contact: Ilene Kasten, MPH, RD, Bureau of Parent-Child Health Services, Mail Stop LC-16, Olympia, WA 98504 (206: 753-7353)

Model Approach to Development of Breastfeeding as a Subspecialty Integrated with Private Sector Maternal/Infant Health Care—Renewable Technologies, Inc.

The goal is to establish a model program of breastfeeding services which provides a permanent, self-supporting means of increasing breastfeeding occurrence and duration. Activities include establishing breastfeeding services as an integral part of prenatal, in-hospital, and postpartum ambulatory care; improving the local climate of support for breastfeed-

ing; participating in breastfeeding promotion efforts with the Montana MCH Bureau; and supporting project replication through information dissemination. Contact: Rita J. Bradley, RD, Project Director, Community Nutrition Division, Renewable Technologies, Inc., 630 Utah Ave., P.O. Box 4113, Butte, MT (406: 782-2386)

Ohio State University Breastfeeding Promotion Project.

The project has two goals: to increase the proportion of low-income women who decide to breastfeed and to assist those who choose to nurse to do so successfully and for a prolonged period. Activities include a retrospective data review of low-income women concerning their infant feeding decisions, the development and testing of interventions to increase the proportion of women who choose to breastfeed, and the development of printed materials—pamphlets written for the 9th grade reading level and posters.

Contact: Linsey K. Grossman, MD, Project Director, University Hospitals Clinic, 456 West 10th Ave., Columbus, Ohio 43210-1228 (614: 293-8034)

Alameda County Infant Feeding Project—Highland General Hospital.

The project staff is studying the babies born at the county public hospital (Highland General) during an 18-month period to determine the rates of infection in breast versus bottle-fed infants in their first year and to evaluate why low-income, minority women initiate or terminate nursing. Staff will also try to promote breastfeeding through community outreach activities and education programs for health providers.

Contact: Laura Finkler, RD, MPH, Highland General Hospital, Room D026, 1411 E. 31st St., Oakland, CA 94602 (415: 532-0275)

Indiana Breastfeeding Promotion Program—Indiana State Board of Health.

The project is promoting breastfeeding among health care professionals, the media, consumers, day care centers, and industry. A statewide survey of consumers to identify attitudes toward breastfeeding and a sur-

vey of physicians and hospitals on breastfeeding management practices have been completed. These surveys will be repeated following the promotion campaign to evaluate its effectiveness.

Contact: Joan Trendell MS, RD, or Chery Smith, MPH, RD, Indiana State Board of Health, 1330 W. Michigan St., P.O. Box 1964, Indianapolis, IN 46206-1964 (317: 633-8518)

Statewide Action Plan to Promote Breastfeeding—South Carolina. The project was implemented in 5 of the State's 15 health districts in 1987, and the remaining districts will be phased in. Activities include developing a liaison program with the office staffs of private physicians, support groups for low income women, and close working relationships with hospital obstetric and pediatric-nursery staffs; conducting a statewide training conference for hospital personnel; and developing an audio-visual presentation on breastfeeding for patients.

Contact: Robert M. Buchanan, Jr., MEd, Division of Children's Health, South Carolina Department of Health and Environmental Control, 2600 Bull St., Columbia, SC 29201 (803: 734-4620)

Tennessee Breastfeeding Promotion Project—Tennessee Department of Health and Environment. This project has developed a model for a comprehensive breastfeeding promotion program involving both the public and private sectors of the medical community. The model is being tested in one urban and two rural health department prenatal programs. Activities include a peer counselor support system, a breast pump loan program, a social marketing project, and a gift of diapers to women completing all required meetings.

Contact: Minda Lazarov, MS, RD, Tennessee Department of Health and Environment, 100 Ninth Ave., N, Nashville, TN 37219-5405 (615: 741-0265)

Committee on Nutritional Status During Pregnancy and Lactation—National Academy of Sciences. The Food and Nutrition Board of the National Research Council's Commission on Life Sciences has established an expert committee to evaluate and document the current scientific evidence and to propose recommendations pertaining to dietary intake and nutritional status during pregnancy and lactation.

The committee will oversee and direct the work of three subcommittees with overlapping membership that will address the following topics: the effect of dietary intake and variations in nutritional status both before and during pregnancy on the patterns of weight gain prior to and during pregnancy, the adequacy of nutrient intake prior to and during pregnancy, and assessment of nutritional status during lactation and guidelines for enhancing it. The reports of the three subcommittees are scheduled to be completed by September 1990.

Contact: Chessa Lutter, PhD, Food and Nutrition Board, National Academy of Sciences, 2101 Constitution Ave., NW, Washington, D.C. 20418 (202: 334-1917)

Training

Lactation Management Continuing Education Project—University of California, San Diego. This project is designed to develop and maintain the expertise of MCH Title V staff in the management and support of lactation and breastfeeding. Through a subcontract, Wellstart/San Diego Lactation Program will provide the educational component. Activities will include recruitment and selection of an appropriate multidisciplinary team of MCH Title V staff from each of the 10 PHS Regions, the conduct of 6-day courses for the teams, and development of a 2-year action plan by each team including conducting at least one educational seminar for MCH staff in each Federal Region.

Contact: Audrey Naylor, MD, DrPH, Director, Wellstart, P.O. Box 87549, San Diego, CA 92138, (619) 295-5192.

Infant Feeding and Growth; U.S.-Related Pacific Islands—University of Hawaii. The purpose of the proposal is to offer a continuing education program on human lactation, infant feeding, and growth monitoring to health personnel in the U.S.-related Pacific islands. Activities include a workshop to train physician-nurse lactation resource teams; development of educational materials, establishment of collection and reporting mechanisms for infant feeding and growth data, and developing a communication network to enhance transmission of information and continuing education about breastfeeding among health personnel, resource teams, and lactation specialists. Contact: Gigliola Baruffi, MD, MPH,

MCH Training Program-School of Public Health, University of Hawaii, Biomed C105M, 1060 East West Rd., Honolulu, HI 96822 (808: 948-8832)

Study Group on Human Lactation and Breastfeeding—University of Rochester. The purpose of the project is to provide a structure for ongoing information access, storage, and retrieval to reflect the state of the art knowledge regarding breastfeeding and human lactation. A network for professionals will be developed that can be called upon for prompt investigation of and response to emerging issues.

Contact: Ruth A. Lawrence, MD, Department of Pediatrics-Neonatology, University of Rochester Medical Center, 601 Elmwood Ave., Box 777, Rochester, NY 14642 (716: 275-4354)

Building Support Networks for Breastfeeding—University of Georgia. The project was designed to implement recommendations from the Surgeon General's Workshop on Breastfeeding through conducting continuing education programs and helping to establish breastfeeding promotion projects at the local level in PHS Region IV. A conference on initiating breastfeeding activities at the local level was conducted for health providers, and the following 10 local breastfeeding efforts were selected as mini-projects.

Contact: Wanda J. Grogan, PhD, University of Georgia, Georgia Center for Continuing Education, Athens, GA 30602 (404: 542-5654)

Development of a Training Course for Paraprofessionals to Promote Breastfeeding Support Networks Among Low-Income Women.

Contact: Gaye Joyner, MS, RD, Director, Bureau of Nutrition, Jefferson Co. Department of Health, 1400 6th Ave., South, Birmingham, AL 35233 (205: 933-9110)

Developing Volunteer Support Groups for Women Who Have Chosen to Breastfeed.

Contact: Janet Allen, RD, Senior Public Health Nutritionist Supervisor, NCF Women's Clinic, 730 NE Waldo Rd., Suite B, Gainesville, FL 32601 (904: 392-4493)

Near to the Heart—Media Approaches to Improve Social Acceptance of Breastfeeding.

Contact: Lisa S. Taylor, MPH, RD, LD, District Nutritionist, District 4 Health Services, 1555 Doctor's Dr., La-Grange, GA 30240 (404: 884-0870)

A Participatory Newsletter for the Promotion of Breastfeeding in the Southeast.

Contact: Beth Everett, RD, MPH, LD, Chief Nutritionist, Maternal and Infant Care Project, Grady Memorial Hospital, 80 Butler St., SE, Atlanta, GA 30335-3801 (404: 589-4932)

Kentucky Breastfeeding Promotion Program: A Social Marketing Approach.

Contact: Carol A. Bryant, PhD, Deputy Commissioner, Lexington-Fayette County Health Department, 650 Newton Pike, Lexington, KY 40508 (606: 252-2371)

Breastfeeding Awareness Project: Training and Referral.

Contact: Carol A. Jones, RD, District Nutritionist, District 1 Health Office, P.O. Box 1055, Batesville, MS 38606 (601: 563-5603)

Educating Health Professionals for Breastfeeding Support.

Contact: Helen Gordon, RN, MSN, CNM, Director, Women and Infant Services, Wake Medical Center, 3000 New Bern Ave., Raleigh, NC 27610 (919: 755-8268)

Increased Breastfeeding in a WIC Population as a Result of Educational Intervention by Health Professionals.

Contact: Edna S. Ceruzzi, MS, RD, District Director of Nutrition, Waccamaw Public Health District, 800 21st Ave., North, Myrtle Beach, SC 29577 (803: 448-8407)

Adolescent Breastfeeding Education in High School.

Contact: Kimberly A. Brown, MA, RD, Public Health Nutritionist, and Nancy T. Richardson, RN, FNP, Family Nurse, Jackson County Health Department, Box 312 Gainesboro, TN 38562 (615: 268-0218)

Self-Teaching Module for Pregnant Women: Breastfeeding Facts and Fiction.

Contact: Ann M. Twiggs, RD, Public Health Nutritionist, First Tennessee Regional Health Office, 122 Southwest Ave. Ext., Johnson City, TN 37605-2966 (615: 929-5900)

Research

Acculturation, Psychosocial Predictors and Breastfeeding—University of Texas.

A biethnic border population (Mexican-American and Anglo-American) is being investigated to determine the effects of culture on behavioral factors that influence initiation of breastfeeding. Appropriate intervention programs to improve breastfeeding behavior may then be designed. Previous investigations have shown that the single most important factor influencing the decision to breastfeed is the mother's ethnicity. Participants in the study will be recruited and interviewed prenatally, when their child is born, and postnatally (2-3 weeks).

Contact: David K. Rassin, PhD, University of Texas Medical Branch, Department of Pediatrics, Route C-5, Galveston, TX 77550-2774 (409: 761-1139)

The Relationship Between Infant Feeding and Infections—Albert Einstein College of Medicine.

To determine if breastfed infants in a western country have a lower rate of infections than nonbreastfed infants, the design of this study incorporates three unique strategies that address deficiencies of prior studies: (a) prospective collection of data to allow for careful surveillance of illness and feeding practices, (b) specific criteria for assessing infections and feeding practices, and (c) monthly questioning of study families about their current feeding practices and illnesses in their infants, especially those illnesses managed at home. The project follows a prospective cohort of 500 infants born at a major teaching hospital in Copenhagen, Denmark, from birth until 12 months.

Contact: David Rubin, MD, Albert Einstein College of Medicine of Yeshiva University, 1300 Morris Ave., Bronx, NY 10461 (212: 430-8580)

Infant Feeding Study—The Johns Hopkins University.

The aims of this completed study were to (a) determine the rates of adoption and duration of breastfeeding in different racial and educational groups; (b) use alternative causal modeling techniques to identify the determinants of breastfeeding, (c) determine the factors which account for the different rates of breastfeeding observed in different educational and racial groups, and (d) determine whether there are differences in the factors which underlie initiation of

breastfeeding and duration and cessation of breastfeeding. More than 700 women in Baltimore City and 200 women on the Eastern Shore of Maryland participated in the study.

Contact: Andrea C. Gielen, ScM., Project Director, The Johns Hopkins University, Hampton House, Fourth Floor, 624 North Broadway, Baltimore, MD 21205-1901 (301: 955-6498)

Copies of the "Report of the Surgeon General's Workshop on Breastfeeding and Human Lactation" and the "Followup Report" are available from the National MCH Clearinghouse, 38th and R Sts., NW, Washington, DC, 20057 (202: 625-8410).

—ELIZABETH BRANNON, MS, RD, and CHARLOTTE WALCH, MA, Bureau of Maternal and Child Health and Resources Development, Health Resources and Services Administration

Estimates of Future Adverse Health Effects of Smoking in China

China stands above all nations in producing and consuming cigarettes (1), a situation which will in time create a serious burden of smoking-related disease in the most populous nation. The future consequences are not yet as apparent as the health effects from the use of tobacco in the United States, which has a longer history of widespread cigarette use and an already substantial smoking-related disease burden (2).

To assess the effects of smoking in the next century, at least three factors must be considered. First, although tobacco has been smoked for many years in China, it traditionally has been smoked not in manufactured cigarettes, but in other tobacco products that may present less risk of lung cancer. During the last several decades, however, there has been an accelerated change to manufactured cigarettes. The switch has been particularly marked in this decade, when cigarette factories began using manufacturing techniques developed through cooperative arrangements with multinational tobacco companies (3).

Second, mass-produced cigarettes are a large source of revenue for the Chinese government because of the high rates of smoking among men and the increasing rates of smoking among women (4). China even is beginning to

export cigarettes to other countries (1). A vigorous black market in American cigarettes has been reported in Shanghai and other cities (5). The government has encouraged the cigarette monopoly to produce similar types of cigarettes to try to counteract the black market.

Third, appropriate information on the personal and health effects of smoking was not distributed in China until recently. The delay in the dissemination of smoking and health information may be attributable partly to the long interval from when cigarette smoking first becomes widespread in a society until the time of peak adverse health effects. Health effects in China will be extensive if smoking prevalence continues at present levels and will be even more extensive if levels increase.

Tobacco Exposure

In 1984, the National Patriotic Health Campaign Committee conducted a survey of half a million persons aged 15 years and older. Among men 20 years and older, 69 percent were current smokers, although many of them used few or no manufactured cigarettes. Among women 20 and older, 8 percent were current smokers (4). Subsequent surveys support these estimates (Peoples Republic of China, Ministry of Public Health: Survey of Urban Health Services in Hubei, Sichuan, and Jilin Provinces, technical report, 1986).

In 1987, 1.4 trillion cigarettes were sold in China, most of which were smoked by men. Cigarette consumption is about 2,300 per adult 20 years or older per year, or 4,200 per man. In the United States, the rate is 3,300 per person per year, with 29.5 percent of men and 23.8 percent of women smoking (6).

Smoking-attributable Disease

The pattern of exposure of the population to cigarettes determines the subsequent pattern of smoking-attributable disease. After a large increase in cigarette use, a delay of some decades may be expected before the main increase in smoking-attributable mortality emerges (7). While the rapid increase in smokers seen in the past 10 years in China may not continue, the rate of production of cigarettes is likely to continue to increase during the next few years. Peak exposure probably has not occurred, and peak mortality will not occur until well into the next century. The main increase in mortality

from lung cancer, for example, may follow increased cigarette consumption by several decades (7).

Outlook

Traditional epidemiologic methods for estimating rates of smoking-attributable disease are based on smoking prevalence, the relative risk produced in other countries by prolonged smoking, and current disease levels (8). These methods will grossly underestimate the future burden of smoking-attributable disease in China. However, a useful estimate may be obtained based upon current cigarette consumption levels in China and direct studies of the effects of prolonged cigarette use in Shanghai and Britain.

If current trends continue, and if there is no significant smoking cessation effort, we estimate that 900,000 lung cancer deaths among men and a total of about 2 million tobacco-related deaths among men will occur in China in the year 2025 (9). About 200 million children living today in China will become regular smokers. Of these, about 50 million, or one-quarter, will die prematurely of smoking-related illness.

The Chinese Ministry of Public Health and the Vice Premier recently expressed concern about smoking in China (10). Official concern, coupled with large-scale health promotion efforts, could bring about a reduction in consumption. A substantial reduction could greatly reduce the estimated numbers of premature deaths from tobacco use during the next century, perhaps from several 10 millions to a few 10 millions of people.

Large scale smoking cessation will decrease population mortality risks from smoking, as documented in the U.S. Surgeon General's reports on the health consequences of smoking (11,12). The impact of high smoking rates in China may yet be softened if health promotion efforts succeed in decreasing the prevalence of smoking among men and in preventing smoking initiation among women.

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Public Health concerning the epidemiology of smoking and smoking-related disease in China.

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HRSA AIDS Curriculum Conferences Assist Primary Care Health Professionals

The dimensions of the human immunodeficiency virus (HIV) epidemic in this country continue to grow rapidly and change. As reported by the Centers for Disease Control at the June 1988 meeting of the Public Health Service in Charlottesville, VA, between 1 and 1.5 million Americans are now infected with the virus. By the end of 1992, 365,000 U.S. acquired immunodeficiency syndrome (AIDS) cases are projected, with 263,000 deaths.

The public health threat posed by AIDS has thrust health professionals into situations where they need to know, to varying degrees depending on the profession, about (a) self-protection for their own safety; (b) diagnosis, management, and referral for

their HIV-infected patients; (c) prevention measures for the families and friends of persons with AIDS and AIDS-related complex and for the general public; and (d) counseling, treatment, and referral for those who are seropositive but not exhibiting AIDS symptoms.

Anecdotal information and small-scale studies, largely of physicians and medical residents, over the past few years have pointed to a considerable degree of concern about acquiring AIDS among health care givers. But these reports have generally concluded that those providers with more information and preparation, including the experience of contact with AIDS patients, reported less negative responses.

It is apparent that the magnitude of the infected population, coupled with the spread of the epidemic, will place new and difficult demands on all health professionals. The demand will be particularly felt by those providing primary health care. In addition, improvements in therapy for HIV-infected persons have made significant changes in both the quality and duration of life; more therapeutic advances will contribute to viewing the care needs of HIV-infected persons as those of the chronically ill.

Two recent reports have emphasized the considerable training needs of health professionals concerning their capacities and capabilities to identify, manage, and help prevent HIV infection. The Institute of Medicine's "Confronting AIDS: Update 1988" acknowledges Federal training initiatives of the Health Resources and Services Administration (HRSA) and the National Institute of Mental Health. However, the report asserts that "the need for such training far exceeds current efforts." Similarly, the "Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic" issued in June 1988 contains a call to action in terms of several recommendations. One in particular, No. 3-46, relates to "the timely development of curriculum changes and new training materials tailored to address the needs of management, health care personnel, and others who are involved in providing care to HIV-infected and AIDS patients."

The Health Resources and Services Administration is the lead agency in the Public Health Service for treatment and care of persons with AIDS and for overseeing the Federal responsibility to train and educate health professionals

to diagnose and manage HIV infection. Within HRSA, the Bureau of Maternal and Child Health and Resources Development and the Bureau of Health Professions are the loci for these activities. These two Bureaus have been working together on a number of AIDS educational activities. Their collaboration has begun to foster the union of two major HRSA missions: leadership in health care delivery for populations with special needs and in health professions education. This union has been accomplished primarily through a new Federal grant program to educate health professionals and through the design and conduct of a conference to promote multidisciplinary cooperation related to HIV infection.

The regional AIDS Education and Training Centers Grant Program was established in FY 1987 with the funding of four projects. Presently, 11 centers across the nation are engaged in the education and training of large numbers of health care personnel. In collaboration with community hospitals, health professions schools, local health departments, and other organizations involved or interested in health professional training, the educational centers are multidisciplinary in nature and geared to train, as a first priority, practicing primary care providers delivering community-based services. In addition, each center is expected to become a regional resource for disseminating current information on AIDS.

Each center prepares health care personnel to counsel, diagnose, and manage patients with HIV infection and their families via (a) training community primary care providers to incorporate strategies for HIV prevention into clinical priorities, (b) training selected trainees to serve as instructors in their local areas, and (c) sensitizing health professionals in their care of AIDS patients through improving their understanding of the complexities of the disease.

At about the same time the Education and Training Center Program began, the HRSA launched another initiative, drawing together health professionals from various disciplines to discuss issues and to design educational strategies relative to the prevention, diagnosis, management, and care of HIV-infected persons. Seven key disciplines were identified as being at the forefront of care, and therefore were the primary disciplines that needed to meet to address professional concerns and issues associated with the HIV epidemic. The seven disci-

plines are medicine (allopathic and osteopathic physicians), dentistry (dentists and dental personnel), nursing (all levels), social work, physician assistant, emergency medicine (technicians and other related personnel), and public health.

For each of these seven disciplines, a task force of from 10 to 20 representative practitioners, educators, and members of professional associations was set up during the summer of 1987. Members of each task force were asked to consider a number of questions on the care of HIV-infected persons from the point of view of their respective professional roles. The core questions posed to members of each single-discipline task force were these:

What are the concerns of your constituency (that is students, residents, and practicing professionals) relative to their preparation to care for HIV-infected persons?

What are the current legal-ethical issues as they relate to members of your profession and their patients or clients?

What is the current status of AIDS education as it effects your profession?

What are the educational gaps within your profession, at all levels, vis-a-vis the AIDS epidemic?

What would be an ideal model of care (including interdisciplinary care) to address the needs of HIV-infected persons?

Given the special concerns of HIV-infected persons, what mechanisms need to be utilized or developed to assure the timely dissemination of new AIDS information to the provider community?

During September 1987, following 1- to 2-day discussions of these issues and concerns, each task force produced a report of its findings, including recommendations for educational strategies and content. Although commonality of purpose, teaching principles, and content had been expected, the similarity of professional concerns expressed by the seven groups was notable. Health professionals and health care workers all appeared to be concerned with the spread of HIV infection, citing three basic reasons: (a) the acceptance and performance of their professional and clinical roles as care givers to their patients and their communities; (b) the realization of their own vulnerability in proximity to HIV-infected persons; and (c) the acknowl-

edgment of their sense of civic responsibility to inform, educate, and prevent the spread of infection among the general public. Virtually all the task force members were cognizant of certain ethical questions, such as "What is the provider's responsibility to inform?", but much less certain of the answers. Agreement was widespread among task force members that an ideal model of care for HIV-infected persons and their families should be a multidisciplinary, case-managed model.

The seven task force reports, each produced separately but through similar processes and evidencing common themes, became background papers for a subsequent Multidisciplinary Curriculum Development Conference on HIV-Infection, held November 16-18, 1987, in Baltimore. Some 100 participants were selected from a broad spectrum of health professions educational institutions, professional societies and organizations across the nation, and they included 2 or 3 representatives from each of the seven task forces. Federal agencies with responsibilities and interest in professional education and training about HIV-infection were also represented. The November 1987 meeting was the first time that these seven health disciplines had joined in consideration of these issues. The conference process was specifically designed to encourage multidisciplinary interaction and greater primary care focus.

A major objective of the 3-day multidisciplinary conference was to develop a consensus on guiding principles which could be applied in formulating education and training programs on AIDS-related issues. This set of principles was to be of particular value to the newly funded education and training centers.

The 100 or so participants were divided into six multidisciplinary break-out groups; each considered the same six topics related to HIV infection: diagnosis and treatment, prevention, counseling the patient and family, provider responsibility—legal and ethical issues, AIDS and the health care providers, and teaching and the delivery of care in a multidisciplinary setting. Following these initial break-out sessions, a second set of sessions was convened, to discuss specific implementation strategies to educate and train professionals within each discipline.

Summaries of the major deliberations of each group were shared in a general session with, again, a surpris-

ing amount of agreement. For example, it was agreed that education should be a major step leading to service delivery, not a separate system that operates in isolation. Further, an optimum balance must be reached within each discipline among requisite knowledge, skills, attitudes, and values to be conveyed to students and practitioners at various levels. Most importantly, the goals for patient care were agreed upon. These included mainstreaming of care (as opposed to creating a separate specialty), emphasis on prevention and ambulatory care, and a multi-disciplinary focus in service delivery. Differences in training strategies and educational methodologies seemed to derive exclusively from distinctions in professional roles.

There were nine outstanding areas of agreement on the educational approaches to AIDS education for health professionals, and these are considered to be the guiding principles that were sought:

1. Health professionals at all levels of education (undergraduate, graduate, continuing and in-service) would benefit from presentation of the facts of the disease, that is, methods of transmission and infection control. Varying emphasis should be placed, depending on the profession, on microbiology, immunology, risk behaviors, patient management, and psychosocial and sexual aspects and counseling.

2. Faculty development will be necessary to implement fully any educational strategy.

3. Coordination of Federal, State, and private support is necessary and desirable to foster enduring curriculum enrichment.

4. Development of models of care, especially multidisciplinary models which define the roles of the different health professionals, will have important educational implications and must be shared with the health professions community. Multidisciplinary instruction is difficult to schedule and is expensive, but educational strategies which lead to teamwork in the care of AIDS patients are necessary.

5. Utilization of professional associations and credentialing organizations to educate, and to influence AIDS education through questions on qualifying examinations, is important. Professional policy statements on AIDS need to be enforced.

6. Careful evaluation of reimbursement standards, particularly for nonho-

spital based care of HIV-infected persons, is recommended.

7. Utilization of persons with AIDS as good teachers for health professionals, and as important members of their own multidisciplinary treatment team, is desirable.

8. Reduction of fear among health professions students is but one goal of AIDS education, but at the same time, educators are inculcating in the students respect for the disease and for the practices of control and prevention.

9. Institution of a timely and authoritative source of AIDS information, including research and pharmacotherapeutic treatment information, for health professionals was considered highly desirable. The form it might take—whether, for example, a clearinghouse or a multidisciplinary journal or the use of the regional AIDS education and training centers as a resource network—was left open.

Emergency Medical Technicians (EMTs) stood out as a large, and, for the most part, unorganized and unevenly informed group of health care providers. It was even suggested that the pool of EMTs is diminishing as a result of the AIDS epidemic. EMTs represent a work force of some 500,000 persons, about 65 percent of whom are volunteers. They appear to be particularly concerned with widespread risk, exposure, and liability issues. Although they do not require long-term information on patients, they are "contact points" who feel they have a right to be informed of their own exposure and to receive special training to meet their needs.

In terms of "next steps" suggested by the conferees, several ideas for followup were offered. The conference participants themselves favored continuing the apparently fruitful multidisciplinary dialogue. They felt challenged to follow through with efforts to build curriculum inroads and team models of care. The Federal role was viewed as central to many of their recommendations, but the need for public-private partnerships was also affirmed.

HRSA accepts as its challenge the further need to tie models of service delivery into the educational channel. Clearly, models of chronic care for the elderly and handicapped already exist.

The conference proceedings are being widely distributed to gain additional feedback on proposed followup activities. Copies of the "Proceedings of the

Multidisciplinary Curriculum Development Conference on HIV Infection" are available from the Health Resources and Services Administration, Rm. 9-13, Parklawn Bldg., 5600 Fishers Lane, Rockville, MD 20857 (tel. 301-443-6745). Information on the education and training center grant program may be obtained from the same source.

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Hospital Administrators Urged to Implement Nonsmoking Policies

The administrators of more than 7,000 hospitals participating in the Medicare Program have been urged by Federal health officials to adopt policies to make their institutions free from tobacco smoke.

Surgeon General C. Everett Koop, MD, and William L. Roper, MD, Administrator of the Health Care Financing Administration, which has responsibility for the Medicare Program, have asked that hospitals establish smoke-free environments because of risks to patients' health from exposure to ambient tobacco smoke.

Their letter to the administrators in May 1988 cited the 1986 Surgeon General's Report, "The Health Consequences of Involuntary Smoking," noting that separation of smokers and nonsmokers within the same air space may reduce, but does not eliminate, the exposure of nonsmokers to environmental tobacco smoke.

"We are especially concerned about smoking in health facilities. Patients in these facilities are probably more susceptible than the general population to the ill effects of passive smoking, particularly children and those with lung or heart conditions. Many are less mobile (or immobile), and thus less able (or unable) to avoid exposure to tobacco smoke," they wrote.

"While some individual hospitals and hospital corporations have voluntarily

adopted smoke-free policies to protect patients and employees, many other health facilities have not," the officials said. "If your hospital has not yet adopted a policy designed to minimize or eliminate the risks to your patients from involuntary exposure to tobacco smoke, we urge you to work with your governing body, medical staff, and other staff to develop and implement such a policy. We encourage you to work toward achieving a totally smoke-free environment as quickly as possible."

Major medical and health care organizations have endorsed the goal of smoke-free hospitals, including the American Medical Association, the American College of Physicians, the American Academy of Pediatrics, and the American Heart Association. Major hospital industry groups are encouraging their members to support policies called for in the letter.

In a related action, Dr. Roper announced his intent to explore the possibility of making smoke-free policies a condition of participation for hospitals in the Medicare Program.

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