Prevention Efforts Slow Worldwide Spread of HIV, WHO Report Says

Mass media campaigns, creative condom marketing programs, and the right messages from friends and coworkers have succeeded in slowing the spread of human immunodeficiency virus (HIV), the AIDS virus, around the world, a new analysis by the World Health Organization (WHO) reports.

In a review of 15 HIV prevention projects carried out in 13 countries, physicians and scientists from the WHO Global Program on AIDS have confirmed the effectiveness of a handful of approaches in producing significant changes in people's sexual behavior.

The specific projects found effective by WHO include the promotion of condom use in Zaire and Thailand, an educational program aimed at long-distance truck drivers in the United Republic of Tanzania, person-to-person AIDS prevention messages in Zimbabwe, and mass media campaigns in the Philippines and Switzerland.

In addition, young military recruits in Rwanda and female prostitutes in Zaire were provided with information about safer sex, condoms, and care for other sexually transmitted diseases that, if left untreated, greatly increase the risk of HIV transmission. These projects were supported by a number of organizations and agencies such as the U.S. Agency for International Development.

Particularly successful have been those approaches that increase the use of condoms.

In Zaire the most outstanding achievement is the dramatic year-by-year increase in condom use. In 1987, fewer than half a million condoms were distributed—mainly by government clinics—for a population of more than 30 million people. Sales of condoms totalled less than 100,000. By 1991, condom sales had soared to more than 18 million.

To achieve this result, in addition to carrying out AIDS awareness campaigns through the mass media, Zaire has relied on commercial marketing techniques. Aptly named and attractively packaged condoms are sold in retail outlets everywhere. Vendors, who are supplied with the condoms free of charge, are inspired by the profit motive to boost sales—they are allowed to keep the small amount they charge for each packet.

Condoms are also being promoted extensively in Thailand, where almost all new HIV infections are a result of heterosexual transmission. Many such infections occur among Thailand's estimated 100,000 sex workers and the men who buy their services. The virus is spread further to other sexual partners of these men and women.

Thai health officials imposed a policy of "100 percent condom use" in the sex entertainment industry. The project worked with both the brothel owners and the women, assuring each group that their incomes would not be affected if condom use became mandatory. They were also informed that noncompliance with the policy would be met with penalties for the brothel owner. The policy was introduced in all establishments in the project area simultaneously, so that clients who visit brothels had little alternative but to use a condom. The strategy is working and has been extended nationwide to 66 of Thailand's 73 provinces.

Another encouraging approach to reducing high-risk behavior and slowing the spread of HIV has been the use of mass media campaigns. In countries as different as the Philippines and Switzerland, such campaigns have achieved impressive results. In Switzerland, a survey showed that as a result of mass media campaigning, the number of young people always using a condom in casual sexual contacts increased from 8 percent in 1987 to 52 percent in 1990. Condom sales in Switzerland have doubled from 7.6 million in 1986 to 13.8 million in 1991.

The Swiss campaign against AIDS, that began in the mid 1980s, initially met with resistance from both politicians and the general public, who were worried that discussion of sex and sexual practices would lead to more promiscuous behavior by young people. This resistance was overcome by establishing an AIDS prevention program based on a sound public health approach. As it turns out, the Swiss experience is that condom promotion does not lead to an increase in casual sex but results in the desired change to safer activity.

One of the most effective approaches reviewed by WHO is a community-based program in Zimbabwe where much HIV transmission is from men who have sex with casual partners and then pass the virus on to their wives. The program organizers chose commercial sex workers and community actors and musicians to act as educators. Using these people to promote condom use among their peers and warn them personally of the dangers of HIV infection has been enormously successful in boosting condom use, proving that advice and support from others in the community are powerful AIDS prevention tools.

Some other examples of successful efforts to slow the spread of HIV

- A community based project was set up in Ciudad Juarez, Mexico, a city bordering the United States that faced a public health nightmare in "La Mariscal," a 7-square-mile area where hundreds of prostitutes work in extreme poverty in about 40 commercial sex establishments. Prostitutes were trained as "peer educators" to spread the message of the dangers of AIDS to their coworkers. At the beginning of the project in 1989, slightly more than half of the prostitutes interviewed could name blood and sex as the principal means of HIV transmission. By April 1991, 98 percent could do so. Sixteen months later, more than 85 percent of the women reported using condoms in 7 or more of the last 10 sexual acts.
- In the Philippines, a survey of the general population revealed that a media campaign on radio and television and in the newspapers had been very effective in raising awareness about AIDS. A total of 96 percent of the young adults sampled said they had seen or heard campaign ads, and more than half of the general population surveyed said they recalled campaign ads promoting a successful AIDS hotline telephone service.
- A pilot program in the United Republic of Tanzania was established along the trans-African Tanduma highway with truck drivers, their assistants, and prostitutes. The drivers are considered a major conduit of HIV transmission because they travel long distances across national borders and visit sex workers during their periods

away from home. In less than a year, the percentage of female prostitutes along truck routes who had used condoms rose from 50 to 91 percent.

• In 1986 the military authorities in Rwanda began an educational program to alert young military recruits to the risks of sexually transmitted diseases (STDs). Before the program's inception, 12 percent of military recruits on average were becoming infected with STDs that caused urethritis each month. During the 2-year program accompanied by the distribution of condoms, this proportion was reduced by more than half, to 5 percent.

• In Zaire, where female prostitutes in the capital city were provided with condoms and free treatment for sexually transmitted diseases by sympathetic health care providers, condom use increased from less than 10 percent to approximately 60 percent in 2 years. When the project began, one-third of the women were HIV-positive, and the level of other STDs was high. Research findings presented to WHO show that as a result of the work, annual HIV incidence declined spectacularly, from 18 percent to 3 percent in just 2 years, along with that of other STDs, such as gonorrhea and genital ulcers.

PHS to Issue 'Passports' in New Prevention Program

The Public Health Service (PHS) has unveiled a unique new campaign to help physicians practice better preventive care and help patients become active partners in maintaining their own health.

Called "Put Prevention Into Practice," the campaign will begin with the issuance of a passport-size personal health guide for adults that will enable patients to keep track of the immunizations, screening tests, and health behavior recommendations that make up good preventive medical care.

"The personal health guide will allow people to become active partners with their physicians in health promotion and disease prevention," according to Louis W. Sullivan, MD, Secretary of PHS' parent Department of Health and Human Services. "It will make it easy for adults to know what shots or screening tests they need, when they need them, and which behavior changes could help them live longer, healthier lives," he added.

A Gallup study commissioned last year by Voluntary Hospitals of America (VHA), the nation's largest alliance of not-for-profit hospitals and multi-hospital systems, showed strong consumer interest in a pocket sized personal health guide. According to the survey, 85 percent of adults would find such a guide "useful" or "very useful."

The methods and materials that compose the "Put Prevention Into Practice" Program were developed by the Public Health Service with assistance from the VHA, which will be the first national alliance of health care organizations to promote and distribute the program information to its more than 860 hospitals across the country.

The PHS campaign was launched in June 1992 at Brooklyn Hospital Center, a VHA hospital and the first in the nation to begin implementing the program through its primary care health network that provides clinical preventive services to Brooklyn's medically underserved families. The network is funded by the New York State Department of Health and the United Hospital Fund of New York City.

President Submits Medical Malpractice Reform Proposal

President Bush has asked the Congress to enact medical care malpractice reforms.

Called the "Health Care Liability Reform and Quality of Care Improvement Act of 1992," the President's proposal is the fourth sent to the Congress to implement his health reform program announced on February 6, 1992. The malpractice plan, submitted in July 1992, would

• Require nonbinding arbitration for alleged malpractice for all health care that the Federal Government pays for or regulates. Such care would include Medicare, Medicaid, and all private plans covered by the Employee Retirement Income Security Act, covering nearly 200 million Americans.

• Establish incentives for States to adopt quality assurance measures and tort reforms.

• Apply those tort reforms to actions brought against the Federal Government under the Federal Tort Claims Act.

• Encourage some States to adopt demonstration projects that would provide for prompt payment of actual losses as an alternative to litigation.

Mandatory Arbitration

The bill would enact a system of mandatory nonbinding arbitration between providers and recipients of health care services for alleged injuries arising out of federally funded or regulated health care and treatment. This system would reduce the burden of needless litigation.

The arbitration system would apply to health care funded by the Federal Government or funded by plans regulated by the Federal Government. This would include Medicare, Medicaid, the Federal Employees Health Benefits Program, military retiree insurance, and all private plans covered by the Employee Retirement Income Security Act.

States would be encouraged to establish arbitration processes for malpractice disputes. Where State arbitration systems are not in place, the Federal Government would provide for an arbitration system. The proposal provides for a form of "loser pays" for legal costs. Under this system, if one party rejects an arbitration award that the other party accepts, but then fails to obtain an outcome that is at least 10 percent more favorable, that party will pay the opposing party's reasonable costs and attorney's fees incurred subsequent to the rejection of the arbitration award.

The Attorney General would implement a similar system that would apply to cases brought against the Federal Government under the Federal Tort Claims Act.

Incentives for Quality and Tort Reforms

States would have 3 years in which to put into place a series of quality and tort reforms. After 3 years, States which had not put reforms into place would face loss of most Federal domestic discretionary funds.

The tort reforms are

• A $250,000 cap on noneconomic damages—those damages beyond compensation for economic harm (for example, for pain and suffering); a waiver may be granted for good cause, such as for States whose constitutions do not permit a cap;

• The elimination of joint and several liability for noneconomic damages (joint and several liability makes each liable party responsible for all costs and damages awarded to the plaintiff);

• The elimination of the Collateral Source Rule to prohibit double recovery by the plaintiff when compensation has been received from other sources such as health insurance;
• Allowing judgments for future costs or damages, such as future medical bills, to be paid in periodic payments rather than as a lump sum; and
• Creating an alternative dispute resolution mechanism that is at least as effective in deterring frivolous actions and producing fair compensation quickly as mediation or pretrial screening panel mechanisms.

The quality reforms are

• Cooperation with Federal efforts to learn the comparative effectiveness of different medical treatments;
• Improved performance in the oversight of physicians by State medical boards; and
• A requirement that physicians sanctioned by the medical boards participate in continuing medical education in areas where the board has found deficiencies.

States could pursue alternatives to the foregoing quality reforms if such alternatives were equally effective. For example, a State could promulgate standards of care that would reduce the need to provide diagnostic tests and practice elements of defensive medicine.

Encouraging Innovation

This proposal provides considerable latitude for States to pursue their own approaches to quality improvement and the elimination of negligence in medical care.

The bill also provides for up to three States to undertake experiments in "prompt payment" approaches, providing prompt payment for economic damages caused by medical injury without any determination of fault.

Johnson Foundation Seeks Proposals for Change in Health Care Financing

The Robert Wood Johnson Foundation is requesting proposals for research, demonstration, and evaluation projects that will produce useful information for major policy changes in health care financing.

The call for proposals is intended to stimulate projects that (*a*) examine the effects of current mechanisms for, and proposed major changes in, the financing of health services on health care costs, access, and quality and (*b*) develop and test new ways to finance care that have the potential to improve access to more affordable health services. Up to $12 million will be made available over 3 years for this initiative.

The foundation's Changes in Health Care Financing and Organization Initiative was announced originally in 1989 and authorized at $12 million. This call for proposals represents a reauthorization of the initiative for an additional $12 million. Letters of intent will be accepted under this solicitation through May 1995 or until authorized funds are awarded, whichever comes earlier.

The initiative is designed to encourage Federal, State, and local officials—as well as private sector policy makers—to collaborate with health services researchers and providers on projects that might examine the health care system's structural strengths and weaknesses or explore alternative approaches to health care financing. The research should be carried out in a time frame relevant to public policy making and have a sound methodology.

Examples of the types of issues that projects might address are the effectiveness of cost control strategies, physician payment reforms, the impact of changes in the regulation and practices of the insurance market, Medicare and Medicaid programs not being studied by Federal or State governments, the design of system-level strategies, such as global budgeting, single-payer authorities, or price and volume controls.

While any topic falling within the broad scope of the program is eligible for funding consideration, targeted solicitations on specific topics of particular interest to the foundation will be announced over the course of the next 3 years. Proposals addressing these specific topics will compete for funding with other proposals submitted under this program and reviewed using the same criteria.

Proposals will be assessed using the following criteria:

• the policy significance of the health care financing mechanism being evaluated or tested,
• the timeliness of the project for informing policy or practice,
• the quality and availability of data to be used, and the strength of the proposed methodology (depending on the focus of the project, primary data collection may be supported or the use of secondary data may be acceptable),
• the uniqueness of the project, and
• the applicant's experience and qualifications for conducting the proposed project and the time commitment of key project staff members who have the skills and experience to perform the various operations and analytic tasks required.

Preference will be given to applicants that are public agencies or are tax-exempt under Section 501(c)(3) of the Internal Revenue Code and are not private foundations as defined under Section 509(a).

Overall direction and technical assistance for the program will be provided by Anne Gauthier, associate director, the Alpha Center in Washington, DC.

Institutions wishing to apply for funds under this program are advised to submit four copies of a letter of intent, rather than a fully developed proposal. The letter of intent should contain the following information about the proposed project:

• a brief description of the topic to be addressed and its significance,
• a statement of the project's principal objectives,
• a description of the applicable research or evaluation methodology (or the demonstration approach),
• dissemination plans, including target audiences,
• an estimated timetable and budget for completion of the project,
• the qualifications of the applicant and key project staff, and
• the name of the primary contact person.

Based on a review of the information in the letter of intent, a full proposal may be requested, usually within 2 months of receiving the letter. If so, instructions will be provided at that time regarding what information to include and how to present it.

The letter of intent should be no more than four double-spaced pages, written on the applicant institution's letterhead, and addressed to Alpha Center, attn: HCFO, Suite 1100, 1350 Connecticut Avenue, NW, Washington, DC 20036, telephone 202–296–1818, FAX 202–296–1825.

"Healthy Start" Projects Aimed at Infant Deaths in 15 Communities

Concentrated efforts are under way to decrease infant mortality, the incidence of low birth weight, and related problems in 15 key communities across the country that have been targeted by the Public Health Service (PHS) Program "Healthy Start" because of their extremely high rates of infant death.

The 15 communities are located in Baltimore, MD; Birmingham, AL; Boston, MA; Chicago, IL; Cleveland, OH; Detroit, MI; Lake County, IN, including Gary; New Orleans, LA; New York, NY; Northern Plains Indian communities in North Dakota, South Dakota, Nebraska, and Iowa; Oakland, CA; Pee Dee Region, SC; Philadelphia, PA; Pittsburgh, PA; and Washington, DC.

Each Healthy Start project area submitted a comprehensive plan in July 1992 detailing local strategies for reducing infant mortality. The PHS Healthy Start Program, administered by the Health Resources and Services Administration, is designed to build on local efforts, and successful methods will be duplicated nationally. Systems of program monitoring and evaluation will be ongoing components of the program.

Although the primary goal of Healthy Start is to reduce infant mortality by 50 percent over 5 years in the selected project areas, the evaluation of progress and impact will look at other health outcome measures as well. Evaluation will collect information about the comprehensive efforts of the project sites and the social, educational, economic, and other environmental factors that lead to success.

Healthy Start Program activities target some of the challenging root causes of infant mortality, such as low birth weight, by providing a comprehensive mix of medical and social services to those pregnant women who need such services most.

Several important principles guide the Healthy Start Programs:

- Encouraging innovation and flexible solutions to delivering care to women and infants while stimulating in expectant mothers a sense of personal responsibility for obtaining preventive health care;
- Ensuring that a comprehensive package of services is provided for women, including substance abuse prevention and treatment programs, child care and transportation to clinics, referrals for housing and job assistance, and streamlined eligibility for services. The concept of one-stop-shopping for these services will be built into program planning;
- Increasing outreach to high-risk women to improve their participation in Medicaid, the Special Supplemental Food Program for Women, Infants, and Children (WIC), and other existing maternal and child health programs;
- Seeking the commitment and participation of local and State government, businesses, schools, neighbors, and families to assure that resources are focused and well coordinated around a strategy to reduce infant mortality.

At the same time, the Healthy Start national public education and information campaign is currently underway to support program efforts. The campaign seeks to alert all Americans to the problem of infant mortality and to encourage them to participate actively in programs like Healthy Start.

The campaign will also educate pregnant women and their partners about the importance of prenatal care and the connection between healthy behavior and birth outcomes. Technical assistance is offered to the 15 communities for their own public education efforts.

Monitoring and evaluating the effectiveness of all program activities are critical features of the Healthy Start project. Since Healthy Start is a national program carried out in 15 communities with local variations in strategy and procedure, the evaluation will incorporate a cross-program analysis that can yield information on the relative success of different methods of implementing programs in reaching common goals.

The United States currently ranks 22nd among developed countries in the world in infant mortality, and each year more than 36,000 American infants die before their first birthday.

While the overall U.S. infant mortality rate has been cut in half since 1970 (1991 provisional data showing a rate of 8.9 infant deaths per 1,000 live births), there is a widening gap between the infant mortality rate of African Americans and whites. Black infants are more than twice as likely to die as white babies, 17.7 deaths per 1,000 live births compared with 8.2 deaths. In addition, the rate at which babies are born at precariously low birth weight (under 2,500 grams) showed no improvement over the last decade. Of all infant deaths, 60 percent are among those who have low birth weights.

In September 1991, President George Bush announced the selection of the 15 Healthy Start communities with $25 million appropriated for the program. In Fiscal Year 1992, Congress appropriated $65 million for Healthy Start with an additional $10 million available for infant mortality reduction activities in community and migrant health centers.

—CHISUN CHU, Project Officer, Healthy Start Office of Planning, Evaluation, and Legislation, and COLLEEN REILLY, Communications Consultant, Healthy Start Program, Health Resources and Services Administration, Public Health Service.

Additional information about the Healthy Start Program can be obtained from Thurma McCann, MD, MPH, Director of Healthy Start, (301) 443–0543.

NIH-NIMH Panel Agrees on Panic Disorder Treatment

An expert panel has reached consensus on treatment of panic disorder, the hit-and-run condition that terrorizes people into thinking they are having a heart attack or are losing their mind. As many as 3 million Americans suffer these panic attacks in the course of a lifetime, and many, as a consequence, avoid public places altogether.

In its consensus statement the panel, convened by the National Institutes of Health (NIH) in conjunction with the National Institute of Mental Health (NIMH), concluded that

- Panic disorder is a distinct condition, with a specific presentation, course, and family history, for which there are effective pharmacologic and cognitive-behavioral treatments.
- Treatment that fails to produce an effect within 6 to 8 weeks should be reassessed.
- Panic disorder patients often have one or more existing mental conditions and thus require careful assessment and treatment.
- The most critical research needs include the development of reliable and valid measures of assessment of panic phenomena, the identification of optimal choices and structuring of

treatments designed to meet the varying individual needs of patients, and the implementation of basic research to define the nature of the disorder.

The panel alluded to several other research needs, including the investigation of treatment-resistant patients, the investigation of combined pharmacologic and psychosocial treatments for patients who have panic disorder with and without agoraphobia, long-term followup studies, investigations of the mechanisms and processes of change, and treatment studies with panic disorder patients who have coexisting mental disorders.

Finally, the panel recommended that NIMH mount an aggressive educational campaign to increase awareness of panic disorder among clinicians, patients and their families, the media, and the general public.

On November 13, 1991, NIMH launched a 3-year panic education campaign that includes the production and dissemination of print and audiovisual information materials for the lay public, health care professionals, and employers about the symptoms and treatment of panic disorder. NIMH will collaborate with professional societies, mental health organizations, and the media to achieve the goals of the campaign.

The panel, convened in September 1991, was composed of experts in psychiatry, psychology, cardiology, internal medicine, and scientific methodology, as well as members of the general public.

Free, single copies of the complete NIH consensus statement on Treatment of Panic Disorder may be ordered from the Office of Medical Applications of Research, National Institutes of Health, Federal Building, Room 618, Bethesda, MD 20892, telephone 301–496–1143.

WHO Begins Research on Drugs and Sports

From cocaine to anabolic steroids, to bloodboosting and human growth hormone, compelling evidence exists that the use of drugs at all levels of sport activity is so widespread that it threatens the safety, health, and longevity of many athletes, according to the World Health Organization (WHO).

In recognition of this widespread problem, WHO has implemented a preliminary cross-cultural research initiative to collect data that can be used to develop substance abuse prevention and education materials. The objectives of the research project include defining drug use patterns with respect to different sports and sport activities, identifying critical health and social problems caused by the use of drugs by athletes, and cataloguing current national and international abuse prevention policies and strategies.

No simple picture of global use has emerged, but what limited research has been done suggests that the problem of drug use poses a far greater health hazard than most people have imagined. Some adverse reactions to anabolic steroids include cholesterol increase, edema, risk of coronary artery disease, liver tumors, prostate enlargement, testicular atrophy, and impotence. There is also evidence of an increase in aggressive and combative behavior ("roid rage") by steroid users.

Limited surveys of athletes in Australia, Canada, Italy, the United Kingdom, and the United States, show that 6–20 percent of athletes questioned have used some form of drug, excluding alcohol and tobacco. On average, approximately 6 percent of those interviewed had used one or more diuretic, anabolic steroid, or stimulant within the previous year.

One significant outcome of these surveys was to illustrate that there are numerous competitors who use a variety of drugs to aid their competitive performance. It was shown also that to some extent drug use affects both sexes, all ages, all sports, and all levels of competition.

There was clear evidence to show that anabolic steroids have moved beyond athletic training and are now being used by nonathletes for cosmetic purposes. In a study conducted in 1988 among high school seniors in the United States, 6.6 percent of all males had taken steroids. Of this group, 35 percent did not intend to participate in school-sponsored athletic programs, and 26 percent cited personal appearance as the primary motive for using the drugs. Furthermore, the data indicated that 38 percent had started using steroids by their 15th birthday.

With the immediacy of modern communication technology and the significance of sports and athletes as role models for children and adolescents, both in developing and industrialized countries, international concern over the prevalence and incidence of drug use in sports has grown. World class athletes are calling for blood testing as a means of controlling doping in sports.

Lower Back Pain, Bed Sores Studied by AHCPR Experts

The Public Health Service's Agency for Health Care Policy and Research (AHCPR) has formed a 23-member panel of private sector health care experts and consumers to develop clinical practice guidelines for diagnosing and treating lower back problems in working-age adults.

At the same time, another AHCPR expert panel has concluded that painful, potentially dangerous pressure ulcers—or bed sores—that affect a significant number of patients in nursing homes and hospitals, can be markedly reduced by simple "low tech" procedures.

One recent study estimated that the cost of medical treatment alone for lower back pain was roughly $18 billion a year. But diagnostic tests, workers' compensation payments, money lost through reduced productivity, and related expenses drive the true cost of low back dysfunction much higher.

Diagnosing the cause of back pain can be difficult, and there is disagreement among physicians as to what constitutes appropriate treatment.

The panel will focus on the diagnosis and treatment of common low back problems within the first 3 months of symptoms, taking psychosocial, economic, and legal issues into consideration.

According to AHCPR Administrator J. Jarrett Clinton, MD, who appointed the panel members, one of its goals will be to reduce the number of persons disabled by low back problems by recommending ways to improve treatment of acute symptoms.

The panel includes practicing physicians, nurses, physical and occupational therapists, chiropractors, researchers, and a consumer representative.

The panel on bed sores advised such procedures as checking patients' skin daily and keeping incontinent patients dry. (Urine can lead to skin breakdown.) In addition, the panel said, immobile patients should be regularly turned or moved and properly

supported by pillows or foam. Mattress overlays can be used to reduce pressure.

Pressure ulcers occur when the skin of bed- or chair-bound persons presses against bony body parts, such as heels or hips. Tissues can ulcerate down to muscle and bone, sometimes causing serious infections and requiring surgery. Besides patients in nursing homes and hospitals, many patients cared for at home are affected.

The panel's recommendations for preventing the development and worsening of ulcerations include

- Aggressive assessment at the time of admission for all bed- and chair-bound persons;
- Periodic reassessment of persons determined to be at risk of developing pressure ulcers;
- Daily skin inspection and care for at-risk persons including keeping skin clean and well moisturized —to help skin resist injury;
- Use of appropriate devices (such as pillows, foam or air mattress overlays, or air mattresses) and techniques (such as frequent repositioning of bed- and chair-bound patients) to help prevent pressure; and
- A team approach, including education programs on pressure ulcer prevention for physicians, nurses, nurse practitioners, geriatricians, physical and occupational therapists, dieticians, patients, families, and care givers.

According to the panel, bed or chair confinement is only one risk factor in developing pressure ulcers. Risk increases with immobility; skin moisture from urinary or fecal incontinence, perspiration, or wound drainage; nutritional deficiencies; and reduced mental awareness. High-risk patients include hospitalized quadriplegics; elderly, hip-fracture patients; other orthopedic patients (especially those with fractures); and persons treated in critical care units.

The 13-member guideline panel consisted of physicians specializing in geriatrics, dermatology, and family practice; nurses in the fields of rehabilitation, gerontology, perioperative care, enterostomal therapy, management, and research; a bioengineer; an occupational therapist; and a consumer representative.

The guideline is the third issued by AHCPR since March 5, 1992. The others were for reducing acute postoperative pain and detecting and treating urinary incontinence in adults. Like these and other guidelines being developed under AHCPR sponsorship, its purpose is to provide health care practitioners with recommendations based on expert opinion and a thorough review of research on the topic of the guideline.

Copies of "Pressure Ulcers in Adults: Prediction and Prevention" and an accompanying quick reference guide and patient guide may be obtained free of charge from AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907; telephone 1-800-358-9295.

PHS Reorganizes Policing of Research Misconduct

The Public Health Service has established an Office of Research Integrity to deal with allegations of misconduct in research funded by PHS.

The new office combines two existing PHS organizations into a single entity reporting to James O. Mason, MD, Assistant Secretary for Health of the Department of Health and Human Services (HHS) and head of the Public Health Service.

The two existing organizations were the Office of Scientific Integrity of the National Institutes of Health and the Office of Scientific Integrity Review.

A major feature of the new organization is an opportunity for a scientist to request an independent hearing if PHS proposes to make a finding of research misconduct. Such hearings will be conducted by a panel appointed by the HHS Departmental Appeals Board that reports to the secretary of HHS and is independent of the PHS.

The reorganization establishes a separation of the investigative and adjudicative functions to assure an objective and fair process. Hearings will provide an accused scientist access to evidence presented by the PHS and the right to be represented by an attorney throughout the proceedings, to question any witnesses presented by the PHS, and to present witnesses and evidence in rebuttal of the charges.

Dr. Mason said, "The new organization and the new policies that will flow from it will not change the fundamental principle that outside institutions receiving PHS research funds, such as universities and medical schools, have the primary responsibility for addressing allegations of research misconduct."

When PHS funds are involved in a research misconduct investigation, the institution must report its findings to the PHS. In most circumstances, PHS will not conduct its own investigation, and will rely on the institution's findings.

The Office of Research Integrity will have responsibility for dealing with allegations of research misconduct in all research supported or performed by PHS agencies. These include the National Institutes of Health, the Alcohol, Drug Abuse, and Mental Health Administration, the Centers for Disease Control, the Agency for Health Care Policy and Research, and the Food and Drug Administration. Because of its special responsibilities as a regulatory agency and its extensive investigative capacity, FDA will continue to conduct its own investigations of alleged misconduct in FDA regulatory research under its bio-research monitoring program.

Dr. Mason named as interim director of the new office, J. Michael McGinnis, MD, currently Deputy Assistant Secretary for Health and Director of the PHS Office of Disease Prevention and Health Promotion.

HHS Adds $2 Million to Grant Programs for Minority Males

The Department of Health and Human Services (HHS) is providing another $2 million for grants to support new projects that will improve outreach and assistance to minority males at high risk of health and human service problems, bringing to $5 million the total funding for the minority male grant program in 1992.

Grants for minority male health and human service efforts were awarded to nearly 100 communities during 1990 and 1991.

"An extraordinary range of public and private organizations have become involved in these projects, and we are eager to recruit even more partners in this effort," said Assistant HHS Secretary for Health James Mason, MD, who heads the Public Health Service.

The new funds will support three types of grants:

1. 1-year grants of up to $20,000 will support local conferences to enable

service agencies and minority community groups to exchange information and develop strategies to assist minority male populations within their communities.

2. 1-year grants of up to $50,000 will support planning and development of minority community coalitions that intend to address specific health and human service problems for defined populations of high-risk minority males.

3. 3-year grants of up to $250,000 per year will support intervention projects that will involve minority community coalitions in carrying out demonstration projects intended to ameliorate public health, social, and related problems that contribute significantly to premature death or poor quality of life.

"This three-pronged approach gives communities in various stages of readiness a variety of tools with which to organize their responses to the crisis of health, education, and employment that affects racial and ethnic populations, and minority men in particular," said Samuel Lin, MD, Acting Deputy Assistant Secretary for Minority Health.

Projects may address health issues such as alcohol and other drug abuse; homicide, suicide, and unintentional injuries; HIV infection and sexually transmitted diseases; or mental health problems. They also may address social issues such as unemployment, undereducation, criminal backgrounds, child abuse and neglect, homelessness, teen-age pregnancy, or family dysfunction.

The grant program is jointly funded by HHS' Administration on Children and Families, Health Care Financing Administration, Social Security Administration, and Public Health Service. It is administered by the Office of Minority Health within the Public Health Service.

Population Growth Threatens Natural Resources Renewal

Developing countries face the problem of making economic progress using natural resources and protecting the environment at the same time: their challenge is to sustain development without outstripping their resources. Achieving sustainable development worldwide while alleviating environmental stress is the focus of a new report on the environmental impact of population growth and the effects of increasing consumption of natural resources.

"The Environment and Population Growth: Decade for Action," a publication of the Johns Hopkins University, describes the consequences of rapid population growth on forests, topsoils, water supplies, and world climate. While growing populations require increasing amounts of food, water, and energy, their increasing consumption and pollution reduce nature's productivity, allowing no time for resources to renew themselves or for technological improvements to take hold, according to the report.

"Current consumption may be diminishing nature's future productivity—not just exhausting current supply but also stealing from our children," according to the report, which calls for concerted efforts to clean up pollution, to preserve natural areas and resources, and to minimize further environmental damage.

People in developed countries comprise less than a quarter of the world's 5.4 billion population, yet they consume roughly three-quarters of its raw materials and energy and produce three-fourths of its solid wastes, the report notes. At current rates of growth, 95 percent of all persons born in the next 35 years will be born in developing countries, however, creating the potential for further environmental damage as they strive to improve their standard of living.

A key component of sustainable development is to slow population growth by helping couples to limit their family size. If fertility were to decline from its 1992 level of 3.4 children per woman, and a 2-child family became the norm during the next century, world population would stop growing at fewer than 9 billion persons. Instead, if a family of 2.5 children eventually became the norm, world population would grow to 19 billion in 2100 and continue to grow.

To stop world population growth at 12 billion—which is more than twice the current level—family planning services will have to serve 50 percent more couples in developing countries by the year 2000, according to the report. Such a goal is attainable because an estimated one in five couples in developing countries already wants to limit or space births but are not using family planning services.

Already signs of environmental strain are appearing. Populations in 80 of 130 countries are growing at serious or critical rates, according to the report. Those 130 countries face critical or serious environmental problems in an average of 4 of 10 environmental quality categories. The report appears in the May 1992 issue of *Population Reports,* a journal published by the School of Public Health's Population Information Program five times a year in four languages for more than 150,000 health care and family planning professionals worldwide, with support from the U.S. Agency for International Development.

Copies of Population Reports, *Volume 20, Number 2, may be obtained from Sharon Rippey, Johns Hopkins University, School of Hygiene and Public Health, 615 North Wolfe St., Room 1605, Baltimore, MD, 21205; tel. (410) 955–7619.*

Secretary Announces 1993 Competition for Students of the Health Professions

Secretary of Health and Human Services Louis W. Sullivan, MD, has announced the 11th annual national competition among students of the health professions for The Secretary's Award for Innovations in Health Promotion and Disease Prevention.

The 1993 competition is open to students enrolled in baccalaureate or higher degree programs affiliated with the Federation of Associations of Schools in the Health Professions, cosponsors of the competition.

Entries will consist of a 2,500-word proposal for an innovative project, including an abstract, and a cover sheet endorsed by the appropriate dean or designated faculty member. The deadline for submission to the faculty advisor or other designated person is April 15, 1993.

Information on the competition may be obtained from the dean or head of the program of the participating academic institution. Awards for the first through third prizes are $5,000, $4,000, and $3,000. Seventeen other awards of $300 are to be made.

* U.S. G.P.O.:1992-312-088:60004