New Directory Offers One-Stop Shopping For NHLBI Materials

The National Heart, Lung, and Blood Institute (NHLBI) has issued a new publication, "Life in the Health Lane," to provide a single, comprehensive overview of the resources available through the Institute. Intended for browsing as well as reference, it also includes ideas on how to use NHLBI materials.

The directory provides descriptions and ordering information for reports, posters, fact sheets, and other materials. It was prepared for health professionals, program planners, and others who work to promote cardiovascular and respiratory health and to enhance the nation's blood supply.

"Life in the Health Lane" also contains brief descriptions of all NHLBI's educational programs and activities, from the oldest—the National High Blood Pressure Education Program, founded in 1972—to the youngest—the National Heart Attack Alert Program and NHLBI Obesity Education Initiative that were launched in 1991.

Copies of the directory and information on available materials may be obtained from the NHLBI Information Center, P.O. Box 30105, Bethesda, MD 20824-0105; tel. 301-951-3260.

U.S. Leads In Funding AIDS Prevention Projects in Third World Countries

To counter what it said was a large amount of misinformation, particularly concerning the role of the United States in addressing AIDS in developing countries, at the global conference in Amsterdam, the Netherlands, in July 1992, the U.S. Agency for International Development (USAID) has issued a fact sheet on its AIDS activities.

According to the USAID summary, the United States leads the world in funding for HIV-AIDS prevention and control activities with 700 programs in more than 70 developing countries. A total of $249 million has been allocated for AIDS programs since 1986, and another $400 million has been committed for the the next 5 years.

Copies of the USAID Fact Sheet and additional information can be obtained from J. D. Deming at 202-647-4274.

NIAMS Schedules Workshop on Epidemiology of Skin Diseases in March 1993

The National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) is planning a Workshop on the Epidemiology of Skin Disease on March 25–26, 1993.

The workshop will be held in Building 31, Conference Room 10, at the National Institutes of Health in Bethesda, MD.

Its objectives will be to

- present a current overview of the present status of epidemiologic research into skin diseases, including but not limited to chronic cutaneous ulcers, dermatologic aspects of HIV infection, ichthyosis, nonmelanoma skin cancer, psoriasis, and toxic epidermal necrolysis,
- identify areas in which epidemiologic studies could advance the understanding, management, and prevention of skin diseases, and
- encourage more research into the epidemiology of skin diseases.

Potential participants include dermatologists and epidemiologists with an interest in skin diseases.

Information may be obtained from Suzanne Sangalan at 301-496-0803.

LETTERS TO THE EDITOR

Environment, Behavior, and Injuries

The article by Sugarman, et al. (*1*), is outrageous. They state that "The health problems of American Indians are related primarily to behavioral risks" and go on to present data from "behavioral risk factor surveys" as indicators of the prevalence of risks that need to be changed. In fact, injury related to environmental factors is the leading cause of deaths of Native Americans and the behavioral surveys have been shown to be invalid.

Among U.S. Navy personnel, Native Americans were hospitalized for alcoholism three times more often than whites, but their hospitalizations for injury per capita were 13 percent less that those of whites (*2*). When environments are similar, injury rates are similar.

Native Americans live disproportionately in rural isolated areas where roads, housing, and other facilities are particularly hazardous.

Surveillance of road conditions in Native American communities and modifications of roads and lighting of roads at high-risk sites have resulted in remarkable reductions in injuries (*3*). A case-control study of falls indicated large differences in dimensions and levelness of stairs as well as falls on stairs at night among people using outhouses because of the lack of indoor plumbing (*4*). A study of child pedestrian injuries indicated that children were often playing in the road because the playground equipment was too dilapidated for use (*5*).

Attribution of injuries to behavior when such conditions are the result of discrimination and poverty is victim-blaming of the worst sort.

Responses to questions in the behavioral risk factor surveys regarding drinking and driving and seat belt use have been shown to be invalid indicators of alcohol involvement in crashes and objectively observed seat belt use among the States (*6*). Alcohol can be objectively measured in drivers in crashes and seat belt use can be observed at roadside locations.

Deaths from infectious diseases among Native Americans were greatly reduced when the Indian Health Service introduced environmental measures and improved health

services in the 1950s. It is past time for those long-known principles of public health to be applied to injuries to Native and all Americans.

Leon S. Robertson, PhD, Nanlee Research, Branford, CT.

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4. Locklear, G. L.: A retrospective case-control study of porch step falls occurring on the Fort Apache Indian Reservation —1987 to 1989. Environmental Health Services Branch, Indian Health Service, Phoenix, AZ, 1991.
5. Price, D.: Motor-vehicle related pedestrian injuries on the Pine Ridge Indian Reservation. MPH thesis. Yale University, New Haven, CT, 1990.
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Sugarman, et al., Respond

We appreciate the opportunity that Dr. Robertson's letter gives us to remind readers that environmental factors, as well as behavioral risks, are important determinants of injury rates among all Americans, not just American Indians and Alaska Natives. However, our article did not attempt to define the relative contributions of behavioral and environmental factors to injury. Rather, we described self-reported behavioral risk factors related to the health status of American Indians and Alaska Natives, how the prevalence of these factors varied by region, and how the self-reported prevalence compared to the Year 2000 objectives.

Dr. Robertson is incorrect in stating that "injury related to environmental factors is the leading cause of deaths of Native Americans." In fact, diseases of the heart account for more deaths than injuries among American Indians and Alaska Natives, and malignant neoplasms account for more deaths than injuries among American Indian and Alaska Native women (*1*). Diabetes mellitus, chronic liver disease and cirrhosis, and cerebrovascular disease also appear in the 10 leading causes of deaths for American Indians and Alaska Natives. Most public health practitioners believe that these important health conditions are, at least in part, associated with behavioral risks. Injury is an extremely important problem among American Indians and Alaska Natives, but it is not the only problem. In addition, although all injuries are related to environmental factors in some way, the relative contributions of adverse environmental exposures and behavioral risks to injury deaths among American Indians and Alaska Natives have not been well established.

Robertson asserts that attribution of injuries to behavior is "victim-blaming." Elsewhere, he has stated that "alcohol contributes to injury by sometimes affecting behavior that places people at greater risk of injurious energy exposure as well as perhaps increasing vulnerability of tissues to injury insults" (*2a*). Robertson neglects to mention that in the study of porch step falls which he cites, 55 percent of falls (and 100 percent of those at night) were associated with alcohol use (*3*). We vigorously condemn "victim-blaming" with regard to the adverse health status of American Indians and Alaska Natives, but we strongly disagree that the study of behavioral risk factors is not worthy of attention.

We agree that it is likely that self-reports underestimate the prevalence of certain risk factors, although we do not accept Robertson's blanket assertion that "behavioral surveys have been shown to be invalid." In any case, a major point of our article—that the prevalence of risk factors such as seat belt nonuse and heavy drinking needs to be reduced—becomes more compelling if the already high reported prevalence of these factors is actually underestimated. Robertson has asserted that resources used for behavioral risk factor surveillance should be directed elsewhere (*2b,4*). We feel that the relatively modest resources used to maintain behavioral risk surveillance are wise expenditures to the extent that the results are used to focus intervention strategies *and* to secure the resources needed to implement these strategies. The Behavioral Risk Factor Surveillance System is an important (even if imperfect) survey of information about the behavioral risk factors of Americans. As to the charge that reporting the results of behavioral risk factor surveys among American Indians and Alaska Natives is "outrageous," we believe that most thoughtful readers of the paper will conclude otherwise.

Jonathan R. Sugarman, MD, MPH, Indian Health Service Epidemiology Program, Seattle, WA, Charles W. Warren, PhD, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control, Atlanta, GA, Linda Oge, Billings Area Office, Indian Health Service, Billings, MT, and Steven D. Helgerson, MD, MPH, Health Care Financing Administration, Region X, Seattle.

References

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