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ABSTRACT

This document is the January 1983 edition of this journal, published monthly by the Center for Health Promotion and Education as a dissemination vehicle for the growing body of information about health education. It includes 195 citations and abstracts of current journal articles, monographs, conference proceedings, reports, and program descriptions. These documents are prepared from information that is provided by the programs themselves or found in directories, newsletters, and similar sources published or created since 1977. The abstracts are arranged in chapters according to their major subject areas, which include the following in this issue: community health education; health education in occupational settings; health education methodology; patient education; professional education and training; regulation, legislation, and administration; research and evaluation; risk reduction; school health education; self care; and sex education. Abstracts are indexed by author, subject, and program title. Information on how to use the journal and how to submit articles for citation also is included. (KC)

January 1983

CURRENT AWARENESS IN HEALTH EDUCATION

81-1790–81-1979

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL
CENTER FOR HEALTH PROMOTION AND EDUCATION
Atlanta, Georgia 30333

CURRENT AWARENESS IN HEALTH EDUCATION

JANUARY 1983

CONTENTS

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INTRODUCTION

Current Awareness in Health Education (CAHE) is published monthly by the Center for Health Promotion and Education as a dissemination vehicle for the growing body of information about health education. It includes citations and abstracts of current journal articles, monographs, conference proceedings, reports, and nonpublished documents acquired and selected by the Center. CAHE also contains descriptions of programs in health education. These descriptions are prepared from information that is provided by the programs themselves or found in directories, newsletters, and similar sources. To make the information in CAHE timely, only documents published or programs of relevance since 1977 are included.

Copies of each document and supporting documentation for each program description are stored in the Center's permanent collection. Users of CAHE are urged to consult local public, medical, and university libraries for individual copies. Sufficient information is provided in the citations to enable users to locate copies or to contact programs.

All persons receiving CAHE are invited to contribute copies of pertinent documents and descriptions of relevant programs for possible inclusion. The Center also welcomes any comments on CAHE and suggestions to improve its usefulness. Write or call:

Centers for Disease Control
Center for Health Promotion and
Education
Attn: Current Awareness in Health
Education
Building 14
Atlanta, GA 30333
(404) 329-3235
FTS 236-3235

Tearsheets for submitting program documents and descriptions of relevant programs are provided on pages vii-viii.

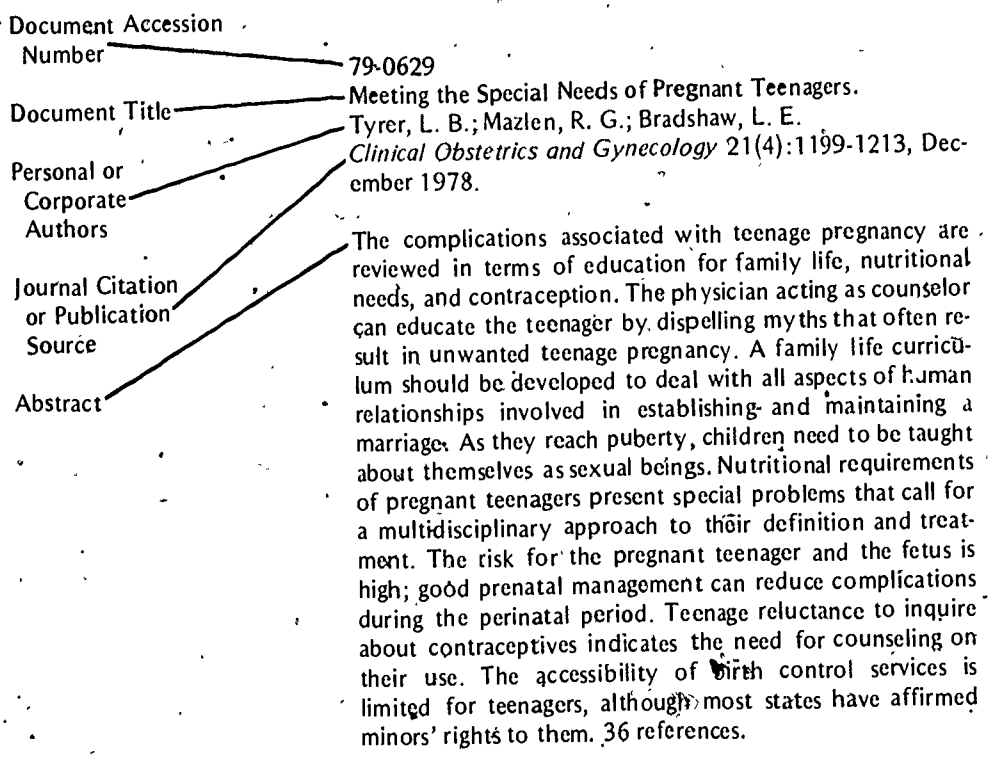
HOW TO USE CAHE

CAHE contains two types of records: informative abstracts of published literature and descriptions of ongoing programs. These records are arranged in chapters according to their major subject area. Chapter headings are used to group items generally related and include: Community Health Education; Health Education in Occupational Settings; Health Education Methodology; Patient Education; Professional Education and Training; Regulation, Legislation, and Administration; Research and Evaluation; Risk Reduction; School Health Education; Self-Care; and Sex Education. The chapter headings reflect active areas in health education as well as major interests of the Center for Health Promotion and Education. To locate specific items of interest, users are encouraged to use the extensive Subject, Author, and Program Title indexes found in the back of each issue.

Within each chapter, citations and abstracts of documents appear first, followed by descriptions of programs. Abstracts with their citations are arranged in alphabetical order by the primary author's name, and descriptions of programs are arranged in alphabetical order by the title of the program.

Each document and program description has a unique accession number. Accession numbers of documents consist of a two-digit prefix indicating the year of publication in CAHE and a four-digit number indicating the publication sequence of the document. For example, 79-0022 indicates the 22nd document appearing in CAHE in 1979. Program accession numbers have a similar format with a "P" added following the year to indicate program, e.g., 79P-0025 indicates the 25th item published in CAHE in 1979, and that the item is a program.

Each document is uniformly identified and described by the elements labeled in the sample below:



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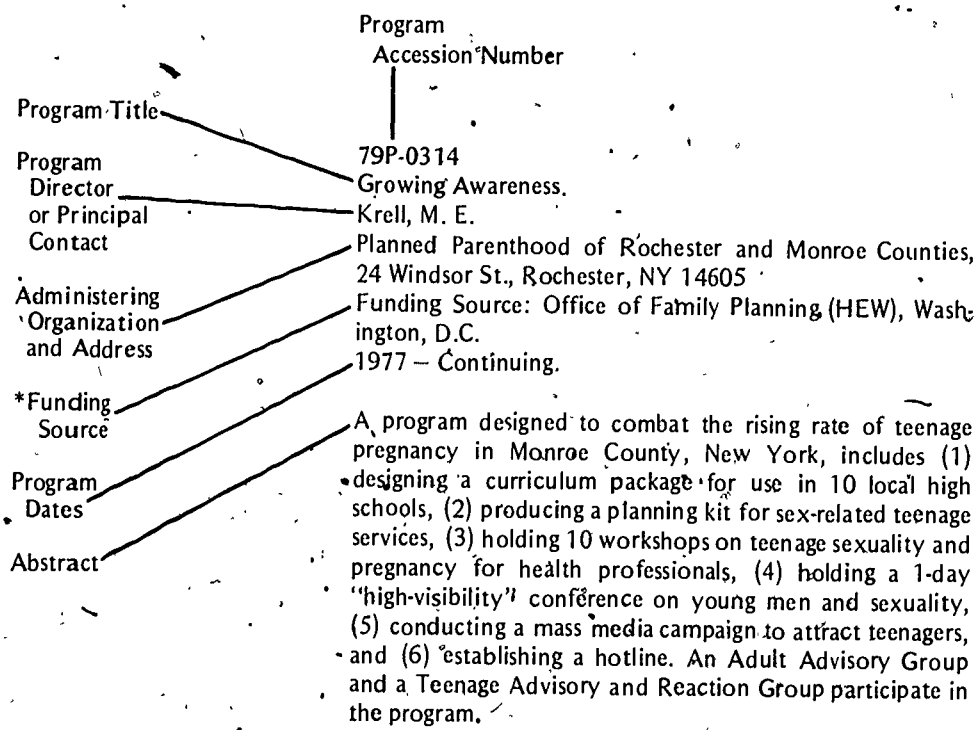
Each program description is uniformly identified and described by the elements labeled in the sample below:



CAHE contains three indexes. They are: (1) Author, which contains the names of personal and corporate authors of documents and directors of programs; (2) Subject, which contains subject descriptors, including geographic location, for both documents and programs; and (3) Program Title, which contains names of programs that are either mentioned in documents or detailed in program descriptions.

*The funding source is specified if the program receives funds from institutions other than the administering organization.

PROGRAM DATA SHEET

The Center for Health Promotion and Education is collecting information about current health education programs for use in *Current Awareness in Health Education* and in analyzing program trends in the field. A program may provide identification, public awareness, coordination, training, demonstration, etc.

If you wish to share your program efforts with other health education professionals, please complete the form below, being as specific as possible in providing information.

We greatly appreciate your taking the time to share your experience with us.

(PLEASE CUT ALONG DOTTED LINE)

1. Program Identification.

   Official Title of Program or Grant and Grant No. _____

   Official Name of the Organization Conducting the Program _____

   _____

   Address of the Organization.

   _____
   street city state zip code

   Program Director _____
   name title telephone area code number

   Principal Contact (if different from Program Director) _____
   name title telephone area code number

   Beginning Date of Program _____ Ending Date, If known _____

2. Funding Source for Your Program

   Please provide the Name(s) and Location(s) (City, State) of Funding Source(s)

   _____

   _____

   _____

3. Focus of Program. ____Administration ____Community Health Education ____Health Education Methodology

   ____Nutrition Education ____Occupational Health Education ____Patient Education

   ____Professional Training Programs ____Research and Evaluation ____Risk Reduction ____Sex Education

   ____School Health Education Other _____

4. Target Population(s) _____

5. Purpose of Program. Please describe the primary purpose of your program

   _____

   _____

   _____

   _____

   _____

   _____

   _____

6. Publications/Information Materials. Please send copies of any publications or material describing your program, if available, or give complete citation (author, title, date, publisher). If no publications exist or are planned, please state how further information may be obtained.

   _____

   _____

   _____

   _____

   _____

THANK YOU.

Name, Title of Person Submitting Program Information

Organization

Street

City, State, Zip Code

Phone

Fold Here First

Place stamp here.

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Center for Health Promotion and Education
ATTN. Current Awareness in Health Education
Atlanta, GA 30333

(PLEASE CUT ALONG DOTTED LINE)

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Staple or Tape

COMMUNITY HEALTH EDUCATION

81-1790
Community Health Education Literature From the Seventies: A Faculty Survey.
Cernada, G. P. and Chen, T. T. L.
International Quarterly of Community Health Education 1(2):195-207, 1980-81.

Faculty members in accredited graduate programs of community health education in U.S. universities were surveyed by mail in 1978 to determine which articles published during the 1970's they would recommend to their colleagues. Annotated citations of 33 of the 71 most widely recommended articles are presented to provide community health educators with a bibliography of essential works in the areas of policy, theory, and social issues.

81-1791
Community Oral Health: A Systems Approach for the Dental Health Profession.
Cormier, P. P. and Levy, J. I.
New York, Appleton, 237 p., 1981.

Guidelines for using systems analysis and evaluation methodology in community oral health programs are provided for use by dental health professionals. Topics include the systems model of community oral health programs, promotion of health via preventive activities, access to care and the distribution of providers, delegation of expanded functions to auxiliary dental health personnel, and organization of providers in more elaborate modes of delivery. The guidelines also cover quality assurance, financial and cost issues, implementation of a community needs assessment, program development and implementation of programming, evaluation, and the future of dental health interventions in society. Numerous references.

81-1792
Older Adult Education.
Forman, J.
Cupertino, Calif., De Anza College, 21 p., April 29, 1980.
Available from: ERIC; Order No. ED-186 077.

To improve the quality of life for the area's elderly residents, De Anza College of Cupertino, California, established an older adult education program that combines physical education with holistic health care principles and instructs participants in relaxation, nutrition, and exercise. Classes are held in convalescent hospitals, retirement homes, and community centers, and instructors are familiar with each participant's case history. The handicapped must obtain a medical affidavit, signed by a physician, which details their condition and limitations; the nonhandicapped must sign a release form indicating that they do not have any of six specified disabilities. All participants undergo a functional ability assessment, which indicates their range of motion, ability to walk, and posture. Courses offered include armchair exercise, yoga, holistic physical movement, minor sports, self-defense, and holistic health. Instructors are trained to avoid activities that are potentially dangerous and to monitor participants for signs of fatigue or overwork. Copies of forms used for case histories are appended. 5 references.

81-1793
Holistic Health: Promises, Problems.
Gordon, J. S.
New Physician 29(6):18, 20-23, June 1980.

Holistic health centers have successfully gathered professionals and paraprofessionals from numerous disciplines to promote self-care efforts among their clients. Using nutritionists, physicians, acupuncturists, exercise physiologists, psychological and religious counselors, and numerous other practitioners interested in holism, the centers concentrate on meeting the physical, spiritual, and emotional needs of their clients. Conventional clinical, laboratory, and diagnostic procedures are often supplemented by exercises designed to promote introspection and self-diagnosis. The centers use instruments and techniques such as visualization, role playing, health hazard appraisal, social readjustment scales, biofeedback, meditation, yoga, jogging, and wellness inventories. Unfortunately, few of the methods used by the centers have been scientifically tested. Hence, a new conceptual framework and new methodologies must be developed for assessing diagnostic and treatment methods used in holistic health practices. More practitioner training and an increased emphasis on quality control are also needed. Finally, an effort must be made to provide middle- and low-income communities with holistic health care services.

81-1794
Lifesavers: The Best Free and Almost-Free First Aid, Health and Safety Things You Can Get by Mail!
Hartunian, P.
1st ed. Montclair, N.J., Tri-Med, 93 p., 1981.
Available from: Tri-Med, 65 Christopher St., Montclair, NJ 07042

Free and low-cost health information materials are provided for health professionals and the general public. The educational aids include booklets, posters, pamphlets, charts, kits, slides, flip charts, catalogues, publication lists, leaflets, and stickers. Title, format, price, source, and a brief description of each citation are provided and classified into 30 health and medical sections.

81-1795
Innovative Approaches in Nutrition Education in the Pacific Region.
Jabre, B.
International Journal of Health Education (Geneva) 24(2):95-101, 1981.

In response to poor nutrition resulting from urbanization in the Pacific Islands, the South Pacific Commission (SPC) has instituted nutrition education programs within the Community Education Training Centre and through the organization of inservice courses for community extension officers. The Community Education Training Centre in Suva provides home economics training to women working at the community level and has established a mobile home economics training unit that is tailored to each community's needs. The unit consists of a nutritionist, a home economist, and an agriculture extension officer. The 4- to 8-week courses provided by the unit help participants to act as a team, develop teaching skills, realize the nutritional value of local foods, and define their roles in efforts to improve family and community health. On the territorial level, the SPC has incorporated consumer nutrition education into the work programs of the women's federation, an organization linking the women's committees that exist in most villages. A new project promoting vegetable gardening for consumption rather than marketing is aimed at women through the federation. All education programs focus on teaching simple and specific nutritional practices. Workshops for school teachers have been conducted to instruct them in the value of indigenous foods and in learning activities that promote such foods. Multimedia presentations are used to promote proper nutrition at meetings of civic groups and during community events. 6 references.

81-1796
Strategies for Achieving Research Utilization in the Bangladesh Population Program: Implications for Health Education.
Khan, N. I. and Reynolds, R.
International Quarterly of Community Health Education 1(2):135-152, 1980-81.

Experiences of the Training, Research, Evaluation, and Communication Centre in Family Planning in Bangladesh and of the organizations that preceded it over a 13-year period (1961-73) demonstrate the need for research in planning social programs and for communication between administrators and researchers. In its early years, researchers were kept outside the system, and the project was perceived as American-directed and internationally and academically oriented. Provincial officials viewed it negatively because it was too "academic." Researchers can improve their relations with administrators and overcome such problems by systematically delineating the roles of administrators, the structural constraints attached to those roles, and strategies that facilitate or impede communication. The early program involved six interrelated communication and utilization subsystems, namely, the Provincial Family Planning Board, the Central Family Planning Council, external sponsors, members of the field structure, clientele, and a linkage system. Special media strategies were developed to channel information throughout these subsystems. To prepare researchers to effectively communicate within such a system, preparation in small group behavior and organizational development is necessary. 31 references.

81-1797
Implementation and Evaluation of a Cancer Information Service.
Kramer, R. M.; Docter, D.; McKenna, R. J.; Irwin, L.; Hisserich, J.; and Hammond, G. D.
International Quarterly of Community Health Education 1(2):153-168, 1980-81.

The Cancer Information Service, a telephone information and referral service for southern California residents, was implemented in November 1976 to provide cancer patients and their families, community physicians, and health professionals access to current information about new methods of cancer detection, diagnosis, treatment, and rehabilitation. Twenty-five paraprofessionals were recruited and trained to staff the information service during normal business hours on weekdays, and a 24-hour line to a national service was provided for callers contacting the service at other times. Oncologists were available to aid paraprofessionals with difficult cases. A policy committee of cancer center administrators, community-based physicians, and communications staff developed guidelines for responses. Each call received by the service was recorded by the counselor on a standard form. From July to September 1978, a survey and satisfaction form was sent to every other caller who requested printed information and one of every five of the remaining callers. Data on the 20,712 calls and 1,822 letters received by the

service during its first 36 months of operation indicate that the impact of a diagnosis of cancer upon patients and their families creates a need for information and support not met by the patient-physician relationship; and that telephone intervention by paraprofessional counselors can be effective in providing information about cancer and its treatment, limited psychosocial support, and referral to community services. 19 references.

81-1798
Cuidaremos: The HECO Approach to Breast Self-Examination.
Lorig, K. and Walters, E. G.
International Quarterly of Community Health Education 1(2):125-134, 1980-81.

To increase the number of Hispanic women practicing breast self-examination (BSE) in Santa Clara County, California, two nurse health educators developed and implemented a program called the Health Education-Community Organization (HECO) model. The model was used to initiate a program entitled "Cuidaremos" (We Will Care for Ourselves). The seven-step HECO model includes specific components to identify the problem, identify community opinion leaders, implement a community survey, produce a media presentation that reflects the community's norms and values, train community facilitators, offer community classes, and evaluate the efficacy of the program. The HECO approach relies heavily on community opinion leaders to influence the target population, and 80 such people were recruited. A survey of 300 households provided a basis for producing a videocassette on BSE, which was later transferred to 8mm and 16mm film. Forty Spanish-speaking women completed 12 to 18 hours of training to prepare them as facilitators of community BSE classes. Surveys of participants before and 6 weeks after a class indicated that the number of women performing BSE more than doubled after participating in a class. 12 references.

81-1799
Respiratory Diseases: Task Force Report on Prevention, Control, Education.
National Heart, Lung, and Blood Inst. (DHEW, NIH), Bethesda, Md. Task Force on Prevention, Control, and Education in Respiratory Diseases.
Bethesda, Md., the Institute (DHEW Publication No (NIH)78-1248), 137 p., March 1977.

The Task Force on Respiratory Diseases of the National Heart, Lung, and Blood Institute was assembled to teach the public about respiratory diseases, the associated risk factors, and available methods of therapy, and to provide the professional community with new information and techniques in the field. After investigating the overall respiratory health of the nation, task force experts addressed smoking as a factor in lung disease, environmental factors in lung diseases, occupational lung diseases, pediatric lung diseases, asthma, chronic obstructive lung diseases, fibrotic and immunologic lung diseases, and infectious lung diseases, and criteria for evaluating educational programs. The task force recommended developing educational programs to (1) increase physicians' awareness of environmental hazards to the lungs, (2) promote physicians' use of pulmonary function tests, and (3) promote use of respiratory therapies. Programs for patients and the public should be instituted to increase awareness of environmental hazards, modify attitudes and behavior in relation to smoking, and develop positive attitudes toward maintaining health. Discussions of prevention and control, pulmonary function tests, health risk appraisals, and the Health Belief Model are appended.

81-1800
Health Education.
Neville, P. J.
International Journal of Leprosy 47(2, Suppl.).446, 1979.

Health education based on assessment of community needs is an essential element of any leprosy control program. The staff of leprosy units should be trained in providing health education services and assessing their outcomes.

81-1801
Evaluation of Nutrition Rehabilitation Centre in Ile-Ife, Oyo State, Nigeria.
Ojofeitimi, E. O. and Teniola, S. O.
World Revue of Nutrition and Dietetics (Basel) 35:87-95, 1980.

Thirty children, 9 months to 4 years old, who were treated at the Nutrition Rehabilitation Centre in Ile-Ife, Nigeria, were studied to evaluate the ability of the center to reduce protein energy malnutrition (PEM). In addition to providing health education to parents, the center serves as a meeting point for public health physicians, nurses, technicians, administrators, politicians, agriculturalists, food technologists, educators, sociologists, and other professionals. The center's program includes demonstrations by nutritionists and meals for children and their mothers. The study assessed the organization of the center, the clients' improvement, and the nutritional knowledge and attitudes of parents, and used home visits to ascertain whether

with digestive health and disease. In working with these groups, the responsibility of the clearinghouse is to aid in distributing, identifying, and producing resource materials. The clearinghouse provides information on current activities and research developments in digestive diseases, factsheets prepared by leading authorities on specific digestive diseases, and an inquiry and referral service that responds to professional and public requests for information. Evaluation data are collected on the number, type, and sources of inquiries, and all publications are extensively reviewed to ensure scientific accuracy and relevance to the patient.

81P-1805
Teen Mothers Program.
Prange, T.
YWCA, 768 State Street, Salem, OR 97301
1967 - Continuing.

The Teen Mothers Program of the YWCA (Young Women's Christian Association) in Salem, Oregon, was established to deal with the problems of teenage pregnancy and parenting. The comprehensive, community-based program offers employment counseling; day care for children of clients; educational counseling and instruction; prenatal classes; family planning counseling; referral services; health classes; child health classes; outreach services; and counseling on parenting, relationships, personal growth, and adoption. Clients have 2 school years (18 months) to complete their work in the program. Eligible women must be 18 years old or younger, pregnant or caring for their own child, and eligible to attend school in the district where they live. The target area consists of Marion, Polk, and Yamhill Counties. Young fathers and families of young parents are encouraged to become part of the program. The program serves over 175 young women each year. Three part-time counselor-social workers and a half-time children's services worker provide individual counseling and supportive services. A social service aide and a half-time family planning aide help the young women make and keep well-child service appointments. The Salem school district provides aides, part-time teachers, and a full-time teacher, and transportation services are provided by two school district drivers. A public health nurse provides prenatal and postnatal classes, and work coordinators manage the employment services offered by the program. Funding is derived from the YWCA, several government agencies, and private sources.

HEALTH EDUCATION IN OCCUPATIONAL SETTINGS

81-1806
Corporate Health Educators Outline Program Objectives, Options.
Employee Health and Fitness 3(6):68-70, June 1981.

Health educators for the Ford Motor Company and the American Telephone and Telegraph Company provided insights into worksite health education approaches and program options during a workshop offered in conjunction with a recent American Occupational Medical Association conference. Planning guidelines for occupational health education programs should include clear and measurable program objectives, a specific methodology, and evaluation criteria and methods. Program selection should match the projected educational and economic outcomes. Central educational outcomes include heightening employee awareness, increasing health knowledge, and modifying employee health behavior. Economic objectives include cost effectiveness and cost benefits. To achieve desired outcomes, health educators should avoid overdependence on technology, use numerous and varied educational aids, develop minimal content requirements, evaluate program effectiveness via pre- and posttesting of employees, and assess employees' behavioral change.

81-1807
Evaluation of an Accident Prevention Campaign in a Major Greek Industry.
Bazas, T. and Harrington, J. M.
International Journal of Health Education (Geneva) 24(2):118-121, 1981.

In response to the high accident rate among industrial workers, a 2-month health education campaign was implemented in November 1980 by a major Greek cotton company that employs 9,000 workers. The campaign was preceded by administration of an 11-item questionnaire designed to assess worker knowledge about the prevention of specific work-related accidents. The questionnaire was distributed with the company's free monthly newspaper. The campaign included distribution of a humorous 32-page booklet on accident prevention, use of posters, reproduction of the booklet in the November and December issues of the newspaper, and publication of the correct answers to the questionnaire. Employees at one spinning mill were urged by a social worker to study the booklet, discuss accident prevention with the company physician, and complete a followup questionnaire. Those who read

the booklet and the newspaper articles improved their scores on the followup questionnaire beyond those workers who read only the booklet or the articles or who read neither. Results of the campaign indicate the need to tailor educational contact to the needs of the target group and to use occupational safety personnel as program promoters. 9 references.

81-1808
USSR: New Training System for Workers Concerned With Food Hygiene.
Loransky, D. N.; Strugatzskaya, L. E.; Gavrilenko, E. V.; and Press, R. S.
International Journal of Health Education (Geneva) 22(4):211-215, 1979.

The Central Institute for Scientific Research in Health Education in the Soviet Union conducted a research program to determine ways to improve the health knowledge of government food service personnel and to increase the efficiency of the existing health training system in the Soviet Union. The program resulted in the development of training programs using supervised and independent learning experiences. All food service personnel are obliged to attend a general lecture on current health problems relevant to their occupation and are given a list of material to read independently. Personnel are also invited to listen to recorded lectures, view films and filmstrips on hygiene topics, and study orientation booklets. The program is repeated every 2 years. Laboratory data and morbidity statistics attest to the efficacy of the program.

81-1809
Physical Fitness in Canadian Business and Industry.
Yuhasz, M.
Business Quarterly (London) 44:72-75, Spring 1979.

More than 150 Canadian companies have initiated fitness programs in the past 5 years and at least 8 companies have hired full-time fitness directors. Provincial Governments began giving support to new employee fitness programs in the 1970's. Company rationale for involvement in such programming includes employee interest, safety benefits, improvement of employee morale and working relationships, reduction of absenteeism, and attraction of new employees. Benefits of fitness programs for participants include improved fitness and health, weight control and improved appearance, stress reduction, and improved social relationships. In 10-week group exercise programs developed for three companies, attendance was high, participants improved their cardiovascular endurance and decreased their body fat; they improved their moods and attitudes, and most reported positive changes in their behavior. A successful program must be staffed by volunteers, directed by a qualified leader, assisted by group participation, accompanied by fitness education and evaluation, supported by unions and management, and publicized. 8 references.

HEALTH EDUCATION METHODOLOGY

81-1810
Skill Development.
Physician's Patient Education Newsletter 3(6):7, 6, December 1980.

Skill development, an educational method that has conventionally been used to improve patients' psychomotor abilities, has been applied to prenatal courses, child care courses, nutrition education classes, family-planning instruction programs, breast self-examination programs, insulin administration programs, parent-effectiveness training courses, values clarification courses, and asthma management courses for pediatric patients. Recent health education programs have also attempted, using biofeedback or meditation, to train people in mental skills related to control of the autonomic nervous system. Others have taught skills associated with communication and decision making. Considering the number of programs using skill development techniques, increased attention to health education research is warranted. 7 references.

81-1811
The Domain of Health: A Conceptual Model Outlining the Scope, Direction and Impact of Health Education.
Allen, R. J.
Paper presented at the Annual Convention of the American Alliance for Health, Physical Education, Recreation, and Dance (Detroit, Mich., April 13, 1980), 13 p., April 13, 1980.
Available from: ERIC; Order No. ED-187 692.

A comprehensive approach to health education requires formulation of a model outlining the scope, direction, and impact of such education on the individual. The fundamental concept in such a model is the interrelationship of physical, mental, and spiritual health. Active reinforcement of the affirmative emotions or positive cognitive reappraisals to help alleviate physical distress are examples of ways to integrate the three aspects of health. An adequate model must account for endogenous factors,

i.e., preestablished conditions or limitations under which the individual acts, as well as exogenous, or environmental, factors. Educational interventions will have the greatest impact on the interactions relating personal health and exogenous factors. Health educators should build upon their traditional role in preserving and enhancing physical health and deal holistically with the spiritual health of individuals. 5 references.

81-1812
A Health Inventory for the School Nurse.
Allensworth, D. D.
Journal of School Health 50(8):486-487, October 1980

A model health inventory for school nurses, teachers, administrators, and parents is provided. The inventory allows users to assess their own health behavior, which is often a model for the children exposed to them. The inventory consists of 23 questions about specific behaviors and 5 open-ended items. 4 references

81-1813
Help Yourself! Give Your Patients a Portion of Good Nutrition Education.
Bowen, E. and Mondschein, N.
Journal of Practical Nursing 30(11):23-24, 65, November-December 1980.

The person best equipped to serve as both a source of sound nutrition education and as a model for good nutritional practice is the licensed practical-vocational nurse (LP-VN). LP-VN's can provide patients with sound nutrition information. The report on nutritional goals for the country developed by the Senate Select Committee on Nutrition and Human Needs is one of the best nutrition information resources available. The findings of the committee indicate that Americans need to eat more fruit, fiber, vegetables, and whole grains; conversely Americans should eat less refined sugar, salt, red meat, fatty foods, and food additives. In teaching patients about nutrition, nurses should emphasize the importance of understanding the reasons for making the recommended dietary changes. Emphasis should also be placed on eating a wide variety of foods. 5 references.

81-1814
The Doctor and the Media.
Byrne, A.
Irish Medical Journal (Dublin) 73(8):292-294, August 1980.

Experiences gained in working on health education programs broadcast by a radio and television station in Ireland reveal the importance of good relations between physicians and the broadcast media. To be considered for broadcast, a program topic must be of medical interest and of interest to the audience. In dealing with physicians, broadcasters often find that physicians (1) are too close to the material and too nervous to be good communicators; (2) avoid important questions on the grounds that the answers would be too complex for the layperson; (3) refuse to criticize peers; (4) are reticent about particulars of their research when working under government grants; and (5) refuse to answer questions. To improve the quality of medical information programs, arrangements should be made to allow broadcasters and members of the Irish Medical Association to discuss pertinent issues and strategies, teach physicians about the broadcast media, and integrate preventive health topics into media programs.

81-1815
Drugs: A Multimedia Sourcebook for Children and Young Adults.
Charles, S. A. and Feldman, S.
New York, Neal Schuman; Santa Barbara, Calif., ABC-Clio, Inc. (Selection Guide Series, No. 4), 200 p., 1980.

Annotated listings of drug education materials targeted for 6- to 12-year-olds are provided for use by teachers and other school personnel. Publications include general nonfiction, personal narratives, and fiction. Audiovisual materials include 16mm films, audiocassettes and discs, filmstrips and slide-tape sets, and transparencies and slides. A list of recommended professional readings, a directory of publishers and distributors, and title and subject indexes are appended.

81-1816
Nutrition References and Book Reviews.
Chicago Nutrition Association, Ill.
5th ed. Chicago, the Association, 76 p., 1981.

An annotated bibliography on nutrition is presented. The citations delineate materials that are recommended, recommended for special purposes, recommended with reservations, recommended for advanced readers, and not recommended. Sources of nutrition information listed include government and quasi-government agencies; professional, voluntary, and industry-sponsored organizations; universities; and commercial sources. A directory of publishers and guidelines for choosing references on nutrition are appended.

81-1817
Life Changes: A Manual of Lessons on Nutrition and Health Considerations for Later Life. Trainer's Guide.
Delaware State Dept of Health and Social Services, New Castle Delaware Nutrition and Health Education Project for the Elderly.
New Castle, Del., Delaware Div of Aging, Dept. of Health and Social Services (Document Control Number 35-14-80-02-01), 203 p., 1980.

Guidelines for teaching the elderly about nutrition and self-care practices are provided for trainers involved with programs for the elderly. Nutrition lessons address use of the four basic food groups in planning diets; location of accurate sources of food and nutrition information; advantages of being at a normal weight; food labels; use of snacks to provide nutrients missing from the three main meals; preparation of economical meals for one or two people; and the value of fiber in the diet. Health lessons address physiological and psychosocial changes that occur during aging, common serious diseases of the elderly, identification of quack cures, reduction of stress, promotion of positive attitudes and healthy lifestyles, techniques for self-examination, assertive participation during visits to health professionals, and home safety. Appendices include a list of educational resources, descriptions of learner evaluation activities, and a list of handouts and teaching aids.

81-1818
Many Healthy Returns.
Echelberger, I. V.; Erickson, M. A.; and Garber, C. M. (South Bend, Ind.). M. A. Erickson, 21 p., (1979).

Instructions and comments on organizing, conducting, and evaluating a nutrition program for older adults are presented. Topics include (1) a food and nutrition knowledge assessment, (2) an evaluation of meal plans to understand the four food-group plan, (3) an evaluation of special diets in relation to the four food-group plan; (4) influences on food intake, (5) the problems that occur in dietary needs management, and (6) the validity of nutrition information in food advertisements, reading material, and labels. A comprehensive bibliography of technical and nontechnical information, teaching materials, cookbooks, and reference lists is provided.

81-1819
Balm for the "Worried Well."
Fields, S.
Innovations 5(3):3-10, Fall 1978.

The Kaiser-Permanente Health Maintenance Organization (HMO) in San Jose, California, refers "worried well" patients to its psychiatry department or to community resources. Five to six percent of the HMO's patients frequently report for treatment but have no symptoms. Using the Holmes Schedule of Recent Events (a self-assessment questionnare) and the Heimler Scale of Social Functioning, personnel in the health appraisal clinic assess social and psychological factors that might influence the patient. Mental health information obtained by the tests includes health concerns, symptoms, relations between symptoms and life problems, likelihood of compliance with recommended treatment, adaptive capacity, psychopathological symptoms, and psychosocial risks. The 5,000 subjects who have completed the tests have been placed by computer into (1) an experimental group whose members are referred to one of the alternative intervention programs, or (2) a control group whose members follow the HMO program. The intervention includes education offered in community settings (colleges, high schools, clinics, and hospitals), visits with the health counselor, and a clinical biofeedback program. A telephone service with 250 health information tapes is also available.

81-1820
Teaching Occupational Safety and Health at the Secondary and College Level. Instructor Guide.
Finn, P.
Reston, Va., American Alliance for Health, Physical Education, Recreation, and Dance, 76 p., 1980.

Guidelines for implementing occupational health and safety education programming are provided for use at high school and college levels. Learning activities cover inspection of the school, interviews with family members, the "job" of being a student, development of an inventory of informational resources, hazard research, interviews with homemakers, motivation of employed people, examination of attitudes toward safety and health, exploration of personality and job satisfaction, promotion of peer education among coworkers, debates over responsibility for safety and health on the job, role playing of conflicts between workers and management, the role of the Occupational Safety and Health Administration (OSHA), debates on controversial occupational and safety health issues, development of hazard inspection checklists, exploration of women's safety and health on the job, and investigation of work stress. Aids provided include an overview of the field, a review of the functions of OSHA, suggestions for enlisting the help of the community, and a list of resources.

81-1821
Breastfeeding Handbook: A Practical Reference for Physicians, Nurses, and Other Health Professionals.
Goldfarb, J. and Tibbetts, E.
Hillside, N.J., Enslow, 256 p., 1980.

Guidelines for educating women about breast-feeding are provided for physicians, nurses, and other health professionals. Topics include an overview of breast-feeding; anatomy, physiology, and composition of human milk; the pharmacology of drugs and chemicals in human milk; advantages of breast-feeding; preparations for breast-feeding during pregnancy and the hospital stay; complications in the immediate postpartum period; breast problems; the learning period; care of the breast-fed baby; care of the lactating woman; the course of normal lactation; relactation and induced nonpuerperal lactation; and devices and techniques used by breast-feeding mothers. Resources for professionals and mothers, resources for devices and other products, and addresses of organizations that promote breast-feeding are appended.

81-1822
Nutrition, Food, and Weight Control.
Hafen, B. Q.
Boston, Allyn and Bacon, Inc., 290 p., 1981.

A practical reference on nutrition, food, and weight control is provided for use by health educators, home economists, nurse practitioners, and other nutrition educators. General topics include basic nutrients, contemporary issues in nutrition, and obesity. Specific topics include the role of agricultural processes in producing food, necessary nutrients, the functions of vitamins and minerals, digestion, absorption, metabolism, assurance of good nutrition, the role of cereals and breads, use of flour and raw sugar, the need for fibers, and vegetarianism. Other topics include nutrition and disease, the role of learning and behavior in nutrition, facts about food additives, nutrition labeling, obesity as a 20th century health problem, weight control fads and fallacies, psychological and sociological problems of obesity, development of obesity in childhood and adolescence, and the dynamics of weight control. Appendices include a glossary of pertinent terms, discussions of nutritive values of foods, teaching ideas, sources of nutrition education information, suggested nutrition references, and optimal combinations of foods. Numerous references.

81-1823
Decision-Making and the Behavior Gap.
Hamrick, M. H.; Anspaugh, D. J.; and Smith, D. L.
Journal of School Health 50(8):455-458, October 1980.

In response to the growing interest in a decision-making approach to health education, a decision-making model was developed to evaluate health problems in the context of knowledge, values, and attitudes. The model assumes that (1) cognitive and affective learning must be equally emphasized; (2) problem solving and creative thinking should be encouraged; (3) a structured process for evaluating decisions should be provided; and (4) students should be involved as much as possible. The sequential phases of the model include defining the problem; identifying possible solutions; collecting, validating, processing, and clarifying values; making a decision; testing the decision; and evaluating the decision. The model breaks each phase into component tasks. One of the unique features of the model is that it integrates behavior into the decision-making process. 4 references.

81-1824
Delphi: Group Participation in Needs Assessment and Curriculum Development.
Hentges, K. and Hosokawa, M. C.
Journal of School Health 50(8):447-450, October 1980.

The Rand Corporation developed a group process, known as the Delphi technique, which was used in needs-assessment and curriculum-development phases of a health education program formulated by the Missouri Department of Elementary and Secondary Education. Delphi is a series of questionnaires that focuses on collating the aggregate judgments of a number of individuals speculating on the future. The questionnaires allow determination of a range of possible program alternatives, exploration of underlying assumptions leading to different judgments, identification of information that may generate a consensus, correlation of informed judgments on a topic spanning a wide range of disciplines, and education of respondents about interrelated aspects of the topic. The 45-day process involves respondents who are motivated and skilled in written communication. The first questionnaire and the cover letter describe the topic broadly and focus on committing respondents to the process. The second questionnaire contains a summary of the findings of the first questionnaire and delineates areas of agreement and disagreement. The final report summarizes the process and product of the two questionnaires. The three-questionnaire series used in Missouri was generally accepted by the 200 involved teachers, 84 percent of whom felt that they had participated in planning the shape and content of the program. 9 references.

81-1825
International Catalogue of Films, Filmstrips and Slides on Public Education About Cancer. First Supplement (Catalogue Nos. 436-574).
International Union Against Cancer, Geneva (Switzerland).
Geneva, Switzerland, the Union (UICC Technical Report Series; v. 54), 187 p., 1980.
Available from: The Managing Editor, International Union Against Cancer, 3, rue du Conseil-General, 1205 Geneva, Switzerland.

A multilingual, annotated catalogue of audiovisual materials on public education about cancer is provided to (1) help cancer societies and leagues and other health education agencies identify and select educational aids for cancer education programs, and (2) provide guidance for organizations planning to produce their own aids. Each entry for the films, filmstrips, or slides includes the entry's title, name and address of producer and distributor, year of production, target audience, type of soundtrack and projection time, price, and a descriptive summary. Annotations are grouped by subject, including general cancer information, checkups, warning signals, smoking, breast cancer, colonic and rectal cancers, Hodgkin's disease, mouth cancer, skin cancer, uterine cancer, cell biology, cancer research, case histories, and rehabilitation for laryngectomees and mastectomees. Each entry has been given a UICC (Union Internationale Contre le Cancer) catalog number. Indexes list the audiovisuals by title, country of origin, language, and the UICC catalog number. Other cancer education publications from the UICC and names and addresses of film distributors are appended.

81-1826
Working With Your Child: Suggestions for Families of the Developmentally Disabled Child.
Joseph P Kennedy, Jr. Foundation, Washington, D.C.
Washington, D C , the Foundation, 2 vol., 218 p., 1980.
Available from: ERIC, Order No. ED-189 822.

Guidelines for caring for developmentally disabled children are provided for use by parents. The guidelines, which are printed in English, Spanish, and Vietnamese, provide information for the parent to share with the child and offer suggestions for activities Topics include physical health and nutrition, mental health, activities of daily living, social behaviors, human sexuality, and safety.

81-1827
Health, Physical Education, Recreation, and Dance for the Older Adult: A Modular Approach.
Leviton, D. and Santoro, L. C., eds.
Reston, Va., American Alliance for Health, Physical Education, Recreation, and Dance, 252 p., March 1980.

A modular training program is provided for health educators, physical educators, recreational personnel, and dancing teachers who work with the elderly. The program comprises (1) four modules on the foundations of gerontological education, including the sociological, physiological, and psychological aspects of aging, and phenomena associated wih death and death-related behavior, and (2) modules on training in creative movement, general fitness, health education, and leisure. A general reading list is appended.

81-1828
"Unfreezing" Lewin: The Case for Alternative Change Strategies in Health Education.
Minkler, M.
International Quarterly of Community Health Education 1(2):169-182, 1980-81.

Kurt Lewin's conceptualization of change as a three-part process of unfreezing, changing, and refreezing remains a key theoretical underpinning of health education practice. While the concept of refreezing change remains an important one in many health education situations, its application in situations characterized by uncertainty and complexity has often been problematic. In these instances, Biller's "contingent change strategies" are a valuable alternative to noncontingent approaches, of which refreezing is a classic example. Lewin's "spiral of steps" approach to action research, Kahn's "agnostic" use of information and theory, and Mathiesen's concept of "the unfinished" represent three such alternative change approaches. The last, in particular, with its emphasis on the process of change rather than its completion, is particularly relevant to those situations in which health educators are concerned with broad systemic change rather than short-term reforms within an existing system. 26 references.

81-1829
Food and Nutrition Education Source List.
Missouri Dietetic Association, Columbia. Community Nutrition Committee and Missouri State Div. of Health, Jefferson City. Bureau of Nutrition Services.
rev. ed. (Jefferson City, Mo.), Department of Social Services, Missouri Division of Health, Bureau of Nutrition Services, 12 p., 1979.

Food and nutrition information sources are provided for dietitians, home economists, nurses, nutritionists, food service personnel, students, teachers, and the general public. The compilation includes the names and addresses of international, Federal, and State agencies; national and State professional organizations; national and State voluntary organizations; commercial sources including food processors, industry-sponsored organizations, pharmaceutical companies, and processors of dietetic products; and university and college departments of nutrition. Publishers of nutrition journals and newsletters are listed.

81-1830
The Doctor and the Media.
Mitchell, D.
Irish Medical Journal (Dublin) 73(8):289-291, August 1980

Participation by physicians as panelists or interviewees on radio and television programs in Ireland has raised some questions about the relationship between the media and physicians. Although it traditionally has been considered offensive if doctors promote their personal or professional standing through broadcast advertising, their involvement with the media, both as performers and as critics, can be beneficial. Suitable program topics include health hazards, health services, ethical problems, and personal health. Before acting as mass media communicators, doctors should assess their abilities as communicators, check any tendencies toward overstatement or dogmatism, prepare to be factual and modest, and consult a recognized professional organization about whether to be identified on the air. The Medical Council could establish a regular review process to monitor programs and investigate and, if necessary, censure or restrict physicians suspected of promoting themselves through the media.

81-1831
A Reappraisal of Mental Health Education: A Humanistic Approach.
Morrison, J.
Journal of Humanistic Psychology 19(4):43-51, Fall 1979.

Evidence from numerous studies suggests that conceptual models other than the medical model would be of greater benefit to the public in understanding their psychological problems. The medical model for the mental health education of the public relies on organic etiologies, a diagnostic procedure that searches for underlying causes of overt symptoms, and a belief that individuals have no responsibility for their behavior. These postulates are diametrically opposed to the humanistic approach, which relies on the ability of human beings to be aware of, choose, and supersede the sum of their parts. The medical model has at least indirectly led to dehumanizing experimentation on mental patients, influenced the public to assume less responsibility for resolving personal problems, and designated the delivery of services as the rightful and legitimate prerogative of medical professionals. The humanistic model, on the other hand, employs psychological interventions that are less drastic and less easily abused, emphasize personal responsibility, induce more realistic expectations of psychological services, and facilitate interdisciplinary action. Seminars designed to "demythologize" mental illness and the medical model have been successful in helping numerous audiences learn about recent theoretical and operational approaches to human behavior. Numerous references.

81-1832
A List of Audiovisual Materials Produced by the United States Government for Alcohol and Drug Abuse Prevention.
National Audiovisual Center, Washington, D.C.
Washington, D.C., the Center, 13 p., July 15, 1980.
Available from: National Audiovisual Center, General Services Administration, Reference Section, Washington, DC 20409.

An annotated list of audiovisual materials produced by the United States Government for use in alcohol abuse and drug abuse prevention programs is provided. Materials include those addressing the effects of alcohol, alcohol use among the young, counseling and rehabilitation for alcohol abusers, the effects of drugs, drug use among the young, counseling and rehabilitation of drug abusers, and the effects of tobacco. Each citation includes the length, producer, title number, price, format, and a short description.

81-1833
Down Syndrome: A Selected List of Lay Materials.
National Clearinghouse for Human Genetic Diseases (DHHS, HSA), Rockville, Md.
Rockville, Md., the Clearinghouse, 3 p., January 3, 1980.

A selected list of educational materials concerning Down's syndrome is presented. Materials include pamphlets, brochures, newsletters, 16mm films, and books. The source for each item is provided.

81-1834
Dietary Lesson Plans for Health Care Facilities.
Owen, L. J.; Rose, J. C.; and Wrase, D. J.
Rochester, Minn., Learning Resources Department, Rochester Methodist Hospital, 314 p., 1979.

Lesson plans to be used by consultant dietitians or other nutrition educators for inservice education are presented. The plans encompass the basic principles of food service administration and clinical dietetics. Each lesson plan outlines a purpose and a time frame, designated participants, objectives, educational activities, necessary materials, evaluation activities, and instructor references. Lesson plans address basic nutrition, menu planning, therapeutic diets, liquid diets, patients unable to feed themselves, minimum residue diets, high fiber diets, sodium-restricted diets, diet and coronary heart disease, diabetic diets, nasogastric tube feedings, and nutrition for cancer patients. Other topics include nutrition during pregnancy, weight control, safe handling of food, cooking skills for the mentally retarded, sanitation, safety in the kitchen, techniques with knives, portion control, standardized recipes, salad preparation, vegetable cookery, food garnishes, leftovers, work simplification, and the metric system. A list of nutrition education resources is appended.

81-1835
A Multiple-Choice Quiz Board for Health Education.
Paton, J. S.; Shaw, A.; Smith, D. C.; and McIntyre, E.
Journal of Audiovisual Media in Medicine (London) 3(3):107-108, 1980.

A quiz board has been developed by Scottish researchers for use in dental health education activities. Unlike other quiz boards produced by the Scottish health education departments, this multiple-choice quiz board does not use an electrical "pen" powered by a battery. (Previous boards using this design were prone to damage if used carelessly.) The new board uses buttons and a direct-current electrical source. The board has been used at the opening day of a new hospital, at a public health exhibition, and in an urban health center, and has proven to be highly attractive to the public.

81-1836
Health Education Without Tears.
Randell, J.
Midwife Health Visitor and Community Nurse (London) 16(6):248-251, June 1980.

Communication between health educator and patient or client is discussed. Communication is rarely isolated from distractions. Interruptions to the educator-client interchange include the professional's experiences; conflicting messages from colleagues; the client's experiences; media messages; and body language. Such barriers can be removed through systematic problem solving. 3 references.

81-1837
Odds On Your Life: How to Make Informed Decisions About the Health Factors You Control.
Roglieri, J. L.
New York, Seaview, 268 p., 1980.

Guidelines for making individual health decisions are provided for those interested in implementing preventive health interventions within the framework of game theory. (According to game theory, the essence of games is the conflict of interest between two or more opponents.) Topics include game theory and its relation to decision making; statistical tables allowing determination of an individual's probability of death, genetic inheritance, lifestyle as an investment and the investment-valuation model; decision making in business, use of the lifestyle investment formula evaluator; multiple simultaneous lifestyle changes; and means of determining the way in which smoking, drinking, accidents, eating, cancer risk factors, and exercise can affect the probability of death. Numerous references.

81-1838
Medical Media Directory.
Roher, L., ed.
Biomedical Communications 9(2):56 p., March 1981.

Listings of over 2,000 media programs developed for use in patient education and other medical education efforts are provided for use with patient, public, and professional audiences. Formats include audiocassette, audiotape, videocassette, film, filmstrip, overhead transparency, overlay, and slide. Topics include alcoholism, anatomy and physiology, anesthesiology, asepsis and isolation, audiovisual production, biochemistry, birth control, cancer, the cardiovascular system, careers, child abuse, clinical laboratories, death and dying, dentistry, dermatology, drug abuse, emergency medicine, endocrinology, gastroenterology, genetics, geriatrics, health and physical fitness, hematology, human sexuality, immunology and virology, internal medicine, medical administration and hospital procedures, and neurology. Other topics include nuclear medicine, nursing, nutrition, obstetrics and gynecology, ophthalmology, orthopedics, otorhinolaryngology, pathology and cytology, pediatrics, pharmacology and toxicology, physical examinations, physical therapy and rehabilitation, psychiatry and psychology, the pulmonary system, radiology, rheumatology, sleep and dreams, smoking, sociological aspects of medical care, surgery, urology and nephrology, venereal disease, and subscription services. Each listing includes a reader service number, medium, running time, accompanying printed materials, foreign language versions, recommended

target audience, producer or distributor, and type of availability (sale, rent, lease-purchase, or preview). A company roster is appended.

81-1839
Health Behavior and Dental Health Education.
Sheiham, A.
New Zealand Dental Journal (Dunedin) 77(347):4-8, January 1981.

An ecological model of dental health education, based on epidemiological data, involves an integrated series of activities carried out by people with various skills and roles The dentist's role is to provide current information about methods of preventing oral diseases; diagnose and treat oral diseases; and encourage workers involved in community organizations, group decision making, public communication, health and social services, and health education to incorporate advice on oral cleanliness into their work. Most oral health education should be conducted by auxiliary personnel. Educational interventions must be designed to be congruent with each individual's sociocultural environment. The educational process should be preceded by an educational diagnosis, i.e., a determination of the patient's view of the illness and treatment and of his or her health knowledge level, and should take place in a nonthreatening setting. The educator should refrain from overreliance on instruction and demonstration, avoid dependence on fixed images of dentists held by the public, and understand that dental beliefs interact with other beliefs and that motives are arranged hierarchically and dynamically. The Health Belief Model, which attempts to predict health behavior or decision making under conditions of uncertainty, constitutes an excellent basis for planning means to overcome noncompliance. Finally, reviews of dental health education programs indicate that a successful program will include several intervention methods, emphasize educational process and target groups, involve parents and communities as well as children, incorporate behavioral objectives, use comprehensive designs, and include an evaluation component. 3 references.

81-1840
Antenatal Education: Guidelines for Teachers.
Williams, M. and Booth, D.
2nd ed. New York, Churchill Livingstone, 206 p., 1980.

Guidelines for implementing prenatal courses are provided. Topics include the aims and history of prenatal education, teaching techniques, audiovisual aids, equipment for and development of classes, discussion of pregnancy, discussion of normal labor, variations in labor patterns, the puerperium and baby care, fathers' sessions, film presentations, and the value of prenatal education. Lists of films, filmstrips, slides, and addresses of pertinent organizations in the United Kingdom and abroad are appended.

81-1841
Collaboration: An Alternative Value and Its Implications for Health Education.
Winder, A. and Kanno, N. B.
International Quarterly of Community Health Education 1(2):183-193, 1980-81.

A healthy society can only develop and be maintained if it is based on collaboration, rather than competition or collectivism. The devaluation of the individual against the social whole, which is central to collectivism, and the dependence on property and consumption, which is central to competition, place human beings under systems that destroy either the uniqueness of the individual (collectivism) or caring relationships (competition). The collaborative mode of social existence is a system in which (1) individuals in a group share mutual aspirations and a common conceptual framework; (2) interactions among individuals are characterized by justice and fairness; and (3) aspirations and conceptualizations are characterized by each individual's consciousness of motives toward the other, by caring or concern for the other, and by commitment to work with the other over time. Public health workers and health educators who are committed to the value of collaboration tend to share an ecological and holistic perspective. Alteration of social and environmental conditions that affect health, rather than encouragement of changes in the behavior that these conditions produce, is central to their views. 27 references.

PATIENT EDUCATION

81-1842
Patient Education: What It Can Do: Where, Who, How--And Why.
Internist 18:8-12, 17, October 1977.

Research on compliance among diabetic and cardiac patients has uncovered a strong correlation between physician-patient communication and fewer errors in taking medication. Nevertheless, a 1975 survey by the American Hospital Association (AHA) revealed that less than half of all hospitals engaged in organized patient education ac-

tivities A concurrent lack of spending on health education by the Federal Government has been reported by the President's Committee on Health Education. Recently, however, support for patient education by the AHA, the Bureau of Health Education, the American Medical Association, and the Blue Cross Association has encouraged the patient education movement. Factors that discourage physician-patient communication include constraints on physicians' time; the crisis orientation of the medical system; failure by physicians to recognize patients' potentials for education; rejection of innovations by physicians; and negative attitudes toward patient education held by physicians, due to previous failures. However, the use of in-office health counselors and community-based education facilities by physicians and medical groups suggests a positive trend. 9 references.

81-1843
Summer Camp for Diabetic Children.
Lamp (Sydney) 37(11).50-51, November 1980.

For the past 5 years, the Newcastle (Australia) Branch of the Diabetic Association, under the supervision of the Diabetic Education and Stabilization Center of Royal Newcastle Hospital, has held a summer camp for up to 30 diabetic children. The camp, which is run for 1 week during the December school holidays, gives the children a summer holiday that emphasizes recreation and enables them to learn how to cope with the routine of diabetic life. Peer modeling and support have proven to be effective means of helping children deal with their disease and its treatment. The staff includes a resident physician, nursing personnel, catering and dietetic staff, physical education and handicraft teachers, and general support personnel.

81-1844
Effects of Physician Communication Skills on Patient Outcomes.
Bartlett, E. E. and Grayson, M.,
Physician's Patient Education Newsletter 3(6):5-6, December 1980.

A research project involving 122 patients educated by residents in the Primary Care Residency Program at Johns Hopkins University in Maryland examined the interrelations among interpersonal skills, number of teaching statements, patient satisfaction, patient recall, and patient adherence to prescribed regimens. The efficacy of the educational visits was measured with structured content analysis of videotapes of the patient-physician exchanges. Use of partial correlations revealed that all effects of interpersonal skills and teaching statements on adherence are mediated by patient satisfaction, recall, or both. When controlling for patient demographic or other control variables, interpersonal skills were somewhat more influential than the number of teaching statements. Additional work is needed to develop an instrument to measure quality as opposed to quantity of teaching and to replicate these findings with other groups of patients and physicians. 4 references.

81-1845
Preparing Patients for Home Parenteral Nutrition.
Bayer, L. M. and Bauers, C. M.,
Patient Counselling and Health Education 2(4):174-177, 1980.

Since 1976, the staff at the Hospital of the University of Pennsylvania has trained 14 people in techniques of home parenteral nutrition (nutritional techniques tailored for persons with injury or illness affecting the small intestines and diminishing absorptive capacity and ability to utilize food). The comprehensive, interdisciplinary program delivered by these and other trained professionals begins with an initial patient assessment that includes medical and motivational evaluation of patients and evaluation of their learning abilities, emotional status, and lifestyles. The teaching phase involves instruction in the tasks necessary to self-administer parenteral nutrition at home. Problems that can arise (chills, fever, or infection at the catheter site) are presented, and problem solving and patient self-monitoring for adverse reactions are emphasized. Weekly outpatient followup is provided in a clinical setting by the interdisciplinary nutrition support service.

81-1846
Effective Communication With Clients: Retention of Information.
Callender, R. S. and Barbour, A.
Journal of Clinical Orthodontics 13(5):321-324, May 1979.

Consultations between physicians and their patients should incorporate elements to reduce the stress of the situation, ensure that all directives are understood and retained by the patient, and ensure compliance by the patient with the prescribed regimen. In such cases, talking to clients directly is more conducive to a positive relationship than using slide shows, filmstrips, or handouts. Repetition of directives by the physician and restatement of information by patients reinforces understanding and retention and makes the consultation less stressful. Patients need to be actively involved in the consultation. 26 references.

81-1847
Available Catalogs or Listings of Sources for Health Education Materials.
College of Medicine and Dentistry of New Jersey-Rutgers Medical School, Piscataway, N.J. Office of Consumer Health Education.
Piscataway, N.J., the Office, 3 p., (197-).
Available from: New York Metropolitan References and Resources Library Agency, 33 W. 42nd St., New York, NY 10036.

Eight general and six subject-specific catalogues or listings of sources for health education materials are provided for those interested in consumer health education and patient education.

81-1848
Sources of Patient Education Materials.
Gotsick, P., Branham, J., and Conley, B.
(Detroit, Kentucky-Ohio-Michigan Regional Medical Library Program), Health Information Library Program, 17 p., (1979).

A directory containing 121 sources of audiovisual patient education materials is provided for use by health educators. The directory includes societies, companies, and institutions with audiovisuals for sale, rent, or loan.

81-1849
An Education Programme for Arthritis.
Gould, R.
Australian and New Zealand Journal of Medicine (Sydney) 8(Suppl. 1):172-173, 1978.

"Living With Arthritis," a community-based course on overcoming everyday difficulties of arthritis, offers patients an alternative to hospital-based treatment. A 90-minute session is conducted 1 night a week for 6 weeks for 25 to 30 patients. Topics include (1) a brief outline on medical aspects of arthritis and available aids; (2) the principles of joint protection and preservation; (3) kitchen use, dressing and personal care, hobbies, work and transportation, and bathroom and toilet use; and (4) relaxation principles and reduction of muscular stress. A panel discussion featuring a rheumatologist, a physiotherapist, a social worker, an occupational therapist, and a member of the Rheumatism and Arthritis Association of Victoria, Canada, is presented at the final session. Most participants are women 40 to 65 years old. The success of the course has led to the implementation of many similar courses.

81-1850
Hypertension: The Problem Patient.
Grenfell, R. F.
Angiology 32(6):373-378, June 1981.

Physicians must be adept at screening, treating, and educating hypertensive patients. An approach to hypertension should be individualized and applied to each clinical setting according to its physical and financial limitations. Outpatient evaluation of the hypertensive patient should begin with a thorough medical history and proceed with a complete physical examination: measurement of blood pressure in both arms and one thigh, visualization of the back of the eye, serological tests, urinalysis, screening for vascular tumors, and an electrocardiogram. The seriousness and chronic nature of hypertension and the need for drug therapy should be explained to patients. Also, patients should be educated about side effects of the drug therapy and maintenance of a proper diet. Office visits scheduled at 6- to 8-week intervals should monitor the effectiveness of the therapeutic program and the patient's compliance. Physicians should be aware that (1) patient compliance may be affected by the cost of drug therapy; (2) the pharmacology of antihypertensive agents and their proper sequence of use influences blood pressure control; and (3) antihypertensive drug effectiveness is decreased when the patient takes oral contraceptives, amphetamines, ephedrine, or steroids. Proper and complete patient education is needed to control hypertension. 7 references.

81-1851
Educational Support Groups for Patients With Ankylosing Spondylitis: A Preliminary Report.
Gross, M. and Brandt, K. D.
Patient Counselling and Health Education 3(1):6-12, 1981.

A study involving 18 patients with ankylosing spondylitis (a form of arthritis) and their spouses assessed the effectiveness of educational support groups (ESG's) in helping the patients understand the illness and its treatment. The study included an 11-patient experimental group and a 7-patient control group. Three ESG's were conducted for the experimental-group members and 10 of their spouses. The control and experimental groups met in weekly 90-minute sessions for a month. Discussion topics were allowed to arise spontaneously, though a facilitator moderated the sessions. An evaluation form was completed by all patients before the first and after the last meeting. The questionnaires were designed to elicit patients' knowledge of ankylosing spondylitis and its treatment and patients' perceptions of their abilities to cope with the disease,

perceptions of the effect of the disease on their family relationships, and perceptions of their adherence to the prescribed regimen Results indicated that the ESG's significantly increased knowledge about the disease and its treatment and slightly improved patient compliance with the prescribed regimen Although analysis of pre- and posttest responses on the questionnaire did not indicate that the ESG's enhanced the patients' abilities to cope with the disease or improved family relationships, verbal feedback concerning these areas was positive in most cases. 14 references.

81-1852
Social and Psychological Responses to Home Treatment of Haemophilia.
Kaufert, J. M.
Journal of Epidemiology and Community Health (London) 34(3):194-200, September 1980.

Twelve severely affected hemophilia patients under treatment at the Hemophilia Center in Churchill Hospital in Oxford, England, and 16 similar patients under treatment at the departments of hematology and community medicine at St. Thomas Hospital in London were studied to assess the effects of transferring patients from outpatient clinics to home treatment. Using a consistent research protocol and similar treatment procedures, home and outpatient treatments were compared at each institution. Questionnaires were administered by an interviewer at the beginning and end of outpatient treatment. After 3 months of home treatment, and again 6 months later, a modified version of the questionnaire was administered by an interviewer to determine how the patient perceived home treatment in terms of changes in lost work time and leisure time, dependence on others, and curtailment of activities. At the outset of the study, patients' degrees of disability were documented by measuring the range of motion for shoulders, elbows, and knees. These measurements were completed on three subsequent occasions, patients' clinical records were reviewed, and unstructured interviews were conducted (with London patients only). Results of these assessments indicated that home treatment reduced delays in receiving treatment and use of analgesics and generally lessened the social and psychological impact of the disease on the patients. A similar study, involving a long-term design, will be undertaken. 16 references.

81-1853
Education and Counselling for Cancer Patients--Lifting the Shroud of Silence.
Lane, D. S. and Liss-Levinson, W.
Patient Counselling and Health Education 2(4).154-160, 1980.

The Brookhaven Memorial Hospital Medical Center, a 350-bed community hospital in Patchogue, New York, has developed a demonstration education and counseling project for cancer patients. The staff includes a coordinator, a nurse specialist with training in cancer care, and a psychologist with training in thanatology and group and family therapy. Public awareness about the project is generated by referrals, newspaper articles, speaking engagements at civic meetings, daily messages broadcast over the hospital's closed-circuit television system, flyers distributed to all admitted patients, and efforts by the public relations department. The counseling program attempts to meet the patients' informational needs as well as their psychosocial needs, particularly those associated with physician-patient communication and patient-family communication. Services include cancer courses, protocols and patient guides, home visitation services, marital therapy, individual and family therapy, group therapy, professional education programs, and community outreach services. Each patient is seen an average of six times, and 25 percent of patient contacts are made in the home. During 2 years of operation, over 2,000 individuals have been served. The program has helped patients become more mobile, comfortable, and psychosocially adjusted. Objective evaluation designs are being implemented. 12 references.

81-1854
Deterioration of Diabetic Patients' Knowledge and Management Skills as Determined During Outpatient Visits.
Lawrence, P. A. and Cheely, J.
Diabetes Care 3(2).214-218, March-April 1980.

The charts of 30 diabetic outpatients, 24 to 74 years old, under treatment at the endocrine clinic of North Carolina Memorial Hospital were studied to analyze the value of a checklist of 22 activities that diabetics need to perform for an adequate home-management program. A diabetes teaching nurse provides one-to-one education to patients during clinic visits and uses the checklist, which is based on behavioral objectives, to document patient education and the level of patient competency. Intervals between assessments of the 30 patients ranged from 3 to 17 months, with a mode of 6 months and a mean of 8.5 months. Scores on checklist assessments indicated an average error rate of 8.5 percent on reassessment. Approximately 33 percent of the patients had an error rate of 10 percent or more. No significant relationship was found between the percentage of error and age, interval between assessments, years that the patient had had diabetes, or past performance on the checklist. There was no indication that performance in the past was an indicator

of errors on reassessment. Although the error rate was lower than rates reported in research that did not make a base-line assessment, it was high enough to indicate that reassessments are needed frequently. 12 references.

81-1855
Performance of Technical Skills of Diabetes Management: Increased Independence After a Camp Experience.
Lebovitz, F. L., Ellis, G. J., III; and Skyler, J. S.
Diabetes Care 1(1):23-26, January-February 1978.

A study of 111 insulin-dependent diabetic children, 7 to 17 years old, who attended a session at the Carolinas' Camp for Children With Diabetes assessed the educational effects of camp experience on independent performance of diabetes-management tasks. Forty-six of the campers had never been to such a facility, while 65 campers had previously attended the camp. Parents of campers completed a questionnare the week before camp, and medical staff interviewed parents and campers on registration day. At the conclusion of the 2-week camp session, the same medical staff completed evaluation forms on campers; a followup questionnare was mailed to all parents 6 months after the session. Chi-square analysis of resulting data indicated that (1) campers significantly improved their ability to administer insulin and test their urine after the camp experience, (2) ability to recognize hypoglycemic reactions and adherence to dietary requirements improved only slightly after the program; and (3) parents thought the camp experience made their children more independent. 8 references.

81-1856
Patient Newsletters--An Extra Effort To Communicate.
Levoy, R. P.
Dental Economics 69(6):65-66, June 1979.

Dissemination of newsletters by dentists has numerous advantages: it allows dentists to compensate for lack of consultation time, reduces patient anxiety about dental treatment, delivers health education messages whenever needed, allows coverage of a topic in depth, facilitates good relationships with patients, involves staff in health education, solicits patient feedback, promotes a good image, keeps the office in touch with inactive patients, and promotes dental care. Topics can include dental definitions, oral cancer warning signals, book reviews, brushing and dental flossing techniques, oral irrigation, professional prophylaxis, dietary influences on dental health, and myofunctional therapy.

81-1857
Helping Your Hypertensive Patients Live Longer.
Maloney, R.
Nursing 8(10):26-34, October 1978.

An examination of two case studies of hypertensives and a review of the scientific understanding of and statistics on hypertension indicate that diligent education of chronic hypertensives will improve their health status significantly and reduce health care costs. An effective patient education program involves explanation of the pathology of hypertension and its ramifications, determination of the degree to which each patient understands the factors that contribute to the disease, instruction in the use and side effects of medication, training in home blood pressure measurement, and reinforcement through frequent reiteration of the education program in subsequent visits. Individual programs for identified hypertensives should be complemented by public education and community screening programs so that the estimated 7 million unidentified hypertensives in the United States and Canada can be treated.

81-1858
Clinical Librarians Join Health Care Team to Provide Information Directly.
Marshall, J. G.
Canadian Library Journal (Ottawa) 36(1-2):23-28, February-April 1979.

McMaster University in Hamilton, Ontario, examined the role of the clinical librarian in providing information to patients and health professionals. In a project begun in June 1975, the clinical librarian at the McMaster University Medical Center participated in conference rounds of the gastroenterology program to determine the information needs of health care team members and their patients. Interviews with professionals and patients provided informal evaluation of the program and a means of basing clinical library services on user needs. A grant awarded by the Ontario ministry of health in March 1978 provided financing for a formal evaluation of the librarian's role in assessing information needs, providing information service to health professionals and patients, and teaching information-seeking skills. Using two part-time clinical librarians and a research assistant, the project provides services to patients and professionals in the rheumatology, obstetrics, neurology, and pediatrics departments, while professionals and patients in four other departments act as controls. In cooperation with other members of the health care team, project staff prepare information packages for patients with various medical conditions. The project staff also cooperate with public libraries on behalf of patients,

collect resource materials that patients have found useful, and collect recent patient education articles for health educators. The evaluation will consist of interviews with professionals and questionnaires administered to patients. 6 references.

81-1859
Renal Transplant: Your Role in Patient Education.
Masur, G.
Journal of Practical Nursing 30(7):12-15, 43, July 1980.

An educational program for patients with transplanted kidneys should include comprehensive prehospitalization, preoperative, and postoperative components. Prehospitalization teaching should provide patients with information on general principles about transplantation and a booklet that explains medications and followup care. Preoperative teaching should include instruction on what to expect before surgery (dietary restrictions, special laboratory tests, and a physical examination), the importance of coughing and deep breathing after surgery, the length of surgery (usually 4 hours), the necessity for close observation immediately after surgery, the need for intravenous feeding and a bladder catheter, the need to undergo a voiding cystourethrogram process, and the possibility that continued dialysis and special dietary restrictions will be required. Early postoperative teaching should educate the patient about common complications, such as polyuria, oliguria, infection, and rejection. The patient should also be instructed about the side effects of immunosuppressive drugs, such as methylprednisolone and prednisone (steroids), and azathioprine. Finally, predischarge teaching should cover permissible physical activities, diet, recordkeeping for medications, daily weight and temperature, and 24-hour urine collection. Through comprehensive patient teaching, the nurse minimizes the fear and anxiety surrounding kidney transplantation and maximizes the chances for a successful operation. 4 references.

81-1860
How to Use Methadone: A Handbook for Patients and Families.
Maxwell, M. B.
Oncology Nursing Forum 8(1):42-45, Winter 1981.

Guidelines on the use of methadone are provided for cancer patients and their families. Topics include fears about addiction, side effects, use of other drugs while taking methadone, use of the drug as a pain suppressant, dosages, possible problems, constipation caused by methadone treatment, and means other than drugs to treat pain and discomfort. 1 reference.

81-1861
The Case for Patient Education: An Update on Recent Court Decisions Affecting Physicians and Hospitals.
McCaughrin, W. C.
Patient Counselling and Health Education 3(1):1-5, 1981.

Recent court decisions relating to the role of patient education in medical care directly affect providers of patient education. Legal precedents emerging during recent years have placed increased emphasis on the patient in terms of adequacy of information provided, the patient's level of understanding, and the duty to inform the patient of the risks of refusing to undergo treatment. In a 1980 decision by the Oklahoma Supreme Court, a precedent was established that places providers in a legally vulnerable position if they fail to inform patients of the risks involved in medical procedures. Court decisions concerning informed consent have suggested that the standard to be applied for determination of consent is subjective, specifically, whether the particular patient would still have consented to the treatment if that patient had been fully informed of inherent risks. A 1980 decision by the California Supreme Court indicated that a patient must be told not only of the risks inherent in the procedure prescribed, but also the risks of not undergoing treatment and the probability for a successful outcome of the treatment. Courts have also recognized the patient's responsibility to follow prescribed treatment regimens. These decisions and others mean that physicians and other health education providers must treat the individual patient rather than the "case" and that hospitals must be careful to enforce rules relating to patient education and informed consent. 21 references.

81-1862
A Simple Technique for Increasing Cancer Patients' Knowledge of Informed Consent to Treatment.
Morrow, G.; Gootnick, J.; and Schmale, A.
Cancer 42(2):793-799, August 1978.

Seventy-seven patients, selected sequentially from patients referred to a radiation clinic for treatment of malignant neoplasms, were tested for immediate recall of information presented, recorded, and signed on informed consent forms. An experimental group of 40 patients was given the complete, unsigned form to take home after the clinical consultation. The 37 patients in the control groups signed the consent form immediately after consultation. Findings showed that patients in the experimental group possessed greater information in virtually every required area of informed consent than patients who signed the form after the usual clinic procedure. The most significant gains were made in patients' understanding of proposed treatment procedures and appropriate treatment alter-

tives. Women recalled more information relevant to informed consent than men did, and a tendency for younger patients to recall more information than older patients was noted. Stresses felt by the cancer patient may undermine the physician's efforts to convey information and advice immediately after the medical consultation. By sending completed, unsigned consent forms home with the patient, associated stresses are lessened, and the physician may add significantly to the patient's understanding of the medical problem, the proposed treatments, and alternatives to those treatments. 22 references.

81-1863
Communicating With Patients: One State Medical Society Has an Innovative Publication Aimed at the Patient.
Mullinax, C. W.
AADE Editors Journal 6(1):8-10, Spring 1979.

In 1975, the Ohio State Medical Association (OSMA) began publishing a monthly patient-oriented newspaper entitled "Your Doctor Reports." The paper was mailed to 11,500 OSMA physician members for use in waiting rooms as a patient health education aid. The publication gradually moved away from its initial emphasis, the socioeconomic aspects of medicine, and concentrated solely on patient health education. In 1978, a new, easier-to-read format was adopted and the name was changed to "Synergy" to stress the shift in emphasis. Each monthly issue covers a wide variety of traditional and nontraditional medical topics. Recent issues have contained articles on low back pain, arthritis, heart disease, child abuse, contact sports, and car safety. Ohio physicians who have a particular subject expertise serve as information sources to provide quality and technical accuracy. In 1979, major corporations were contacted about purchasing "Synergy" to promote employee health education, and several corporations, clinics, and hospitals subscribe to the publication. In addition, several State medical societies are interested in starting similar publications, and others have requested that "Synergy" be syndicated.

81-1864
Childhood Rheumatic Diseases: Patient, Family, and Teacher Education Materials.
National Inst. of Arthritis, Metabolism and Digestive Diseases (DHHS, NIH), Bethesda, Md. Arthritis Information Clearinghouse.
Bethesda, Md., the Clearinghouse, 5 p., October 1980.

Annotated citations of patient, family, and teacher education materials related to childhood rheumatic diseases are provided. 19 references.

81-1865
Outcome Standards for Cancer Nursing Practice.
Oncology Nursing Society, Oakmont, Pa. Clinical Practice Committee.
Kansas City, Mo., American Nurses' Association, 14 p., 1979.

Outcome standards for nurses caring for cancer patients are provided to reorient nursing care toward cancer as a chronic, rather than acute, disease. A standard (goal), set of rationales, and set of outcome criteria are presented for each area of nursing practice, including prevention and early detection, information, coping measures for patients and families, assurance of comfort, nutrition, protective mechanisms, mobility, elimination (managing changes in the body's elimination of waste), sexuality, and ventilation. A glossary and bibliography are appended.

81-1866
Waging the War With Cancer: An In-Depth Re-Educative Process.
Pohl, C. R. and Nash, G. S.
Presented as a Workshop Paper during the College of Chaplains Convention, American Protestant Hospital Association; Dallas, Texas; March 13, 1978, 9 p., March 13, 1978.
Available from: author, Oklahoma Wellness Center, 13401 North Pennsylvania, Oklahoma City, OK 73120.

Individuals can effectively cope with cancer if they (1) view it as chronic rather than fatal, (2) assume an active part in the rehabilitative process, and (3) develop family support systems. The Oklahoma Wellness Center in Oklahoma City offers three programs, the Family Class, the Oncology Tutoring Program, and MITE (Mastectomy Isn't The End), that employ a "will-to-live" approach. The programs emphasize self-help, goal setting, and group support. Program implementation encountered many problems, including the social view of cancer as fatal, physicians' reluctance to allow nonprofessionals to counsel their patients, hospital personnel who expect cancer patients to die, patient depression, family overprotectiveness, administrative barriers erected by hospitals, and staff resistance to an optimistic view of cancer. An inservice program is needed to convince professionals that cancer is not always terminal and that patients must be made to understand its chronic nature. 6 references.

81-1867
The Hemophilia Educational Resources Project.
Resnik, S. G. and Levine, P. H.
Physician's Patient Education Newsletter 3(6):3-4, December 1980.

As a result of information obtained from a 1979 survey conducted by the National Hemophilia Foundation (NHF), a project was established under the aegis of the NHF Nursing Committee to develop the Hemophilia Patient-Family Education Model. The model is a teaching tool to be used by nurse coordinators who serve as patient and family educators. The model was pilot tested at 11 hemophilia treatment centers. The model uses an instruction booklet, flip charts, a learner-educator contract, an educational assessment sheet, seven teaching modules, a selected list of references, and an evaluation sheet. The teaching model was rendered acceptable for use by social workers, genetic counselors, and nurses. The physician can help to implement the model by acknowledging the nurse coordinator as the primary educator and by encouraging the use of other team members as ancillary educators.

81-1868
Behavior Modification for Orthodontic Patients: An Exploratory Approach to Patient Education.
Rich, S. K.
American Journal of Orthodontics 78(4):426-437, October 1980.

Fifty-three orthodontic patients 8 to 18 years old, under treatment by two orthodontists, were studied to assess the efficacy of a behavioral counseling program that emphasized a combined effort on the part of the patient and the patient's parents. Subjects were identified by their dentists as having chronic plaque accumulation and gingival inflammation. The educational program involved behavioral counseling during three sessions held at 2-week intervals. One parent was usually included in the first session. This personal counseling was supplemented by demonstrations, lectures, self-instruction, and behavior modification. The behavior modification program included a contract signed by the parents and the patient, a monitoring card to record toothbrushing behavior, a rising-and-retiring survey to identify morning and evening oral hygiene habits, and a list of activities (reinforcers) that parents could offer as rewards. Nonstatistical analysis of the program and a particular case indicated that (1) presentation of the reinforcers generally caught the attention of the patient, but the reinforcers were not enthusiastically received by the parent; (2) involvement of parents in the initial session was beneficial, (3) the system was most effective with children 8 to 13 years old; (4) verbal reinforcement by the health educator was essential to all sessions; and (5) precise measurement of gingiva and plaque accumulation and an emphasis on long-term behavior change would have improved the study design.

81-1869
Patient Compliance.
Robbins, J. A.
Primary Care 7(4):703-711, December 1980.

No study has been able to offer a universal solution to noncompliance by patients with prescribed therapeutic regimens. Studies measuring patient compliance via pill counts, urine analysis, and plasma assays have indicated that compliance rates rarely exceed 50 percent. Though many physicians claim to intuitively predict patient compliance, studies investigating this claim suggest it is false. Methods effective in some settings are often ineffective in others. Similarly, under experimental conditions, patient education, encouragement of patient involvement, provision of feedback to the patient via serum drug monitoring, and use of simplified drug regimens have all proven inadequate for consistently ensuring compliance. Although these methods have helped in some cases, they cannot be trusted when the therapeutic intervention is of great significance. In these cases, patient participation should probably be eliminated. 21 references.

81-1870
Preaching in Your Practice: What to Tell Patients to Help Them Live Longer.
Robbins, J. A.
Primary Care 7(4):549-562, December 1980.

Rather than simply prolonging life after disease develops, medical intervention should prevent conditions that contribute to early death. Primary care physicians should discuss with patients the effects of smoking, excessive alcohol consumption, obesity, and an inactive lifestyle. Physicians should be able to instruct patients about precautions to reduce deaths by homicide, suicide, motor vehicle accidents, and difficult pregnancies. Graphs and tables are provided presenting epidemiological data on leading causes of death; leading causes of death for men and women; years lost due to premature death, annual death rates in relation to smoking; and cholesterol and cardiovascular diseases. 28 references.

81-1871
An Educational Program for Psoriatics: An Evaluation.
Rothman, A. I.; Byrne, N.; Schachter, R. K., Rosenberg, L.; and Mitchell, D.
Evaluation and the Health Professions 3(2).191-203, June 1980.

Ninety-one patients with psoriasis who were referred to the dermatology service at Women's College Hospital (affiliated with the University of Toronto) and who satisfied

certain criteria relating to the severity of their condition, age, and the absence of coincident conditions were randomly assigned to an experimental patient education group or a control group. The patients in the control group received the normal treatment given patients at the dermatology service, while the experimental-group patients received 3 weeks of day care and education at the Psoriasis Education and Research Center (PERC). Upon admission to PERC, medical histories were taken, physical examinations were conducted, and participants were photographed by a standard procedure. A functional history was taken concerning ability to cope at home, at work, and in social settings; the extent and appropriateness of self-care practices; knowledge about the causes of and functional changes accompanying psoriasis; and the names and actions of the medications they were using. Individualized patient education programs were designed with reference to the medical and functional information and implemented during the 3 weeks of care. Photographic assessments and functional histories were taken at 3 weeks, 6 months, and 12 months. Hospital patients were reassessed at 6 and 12 months. Comparison of PERC patients with hospital patients indicated that the PERC patients exhibited greater functional capacities and more pronounced decreases in skin problems. 14 references.

81-1872
Preparing Children for Surgery.
Schrader, E. S.
NATNews 17(6):11-14, June 1980.

The increase in the number of children undergoing surgery, which has resulted from advances in surgical techniques and increased availability of government and private health insurance, has resulted in changes in how children are prepared for operations. Parents, who were previously allowed to visit their children only a few hours a week, are now typically allowed unrestricted visiting privileges, and many hospitals provide accommodations so mothers can stay with their children. Many hospitals in the United States use coloring books, booklets, and puppets and dolls and have instituted preadmission tours to familiarize children with hospital procedures and to soften the trauma of admission and treatment. Occasionally, well children are given tours to acquaint them with the hospital at a nonthreatening time. Nursing intervention for children undergoing surgery often begins in the surgeon's office. Experience has shown that children who are prepared for their surgery recover more quickly and have fewer complications than do children who are not prepared. 9 references.

81-1873
Health Education and Alternatives to Drugs.
Sheeran, M. M.
World of Irish Nursing (Dublin) 9(3-4):6-7, March-April 1980.

The vast expenditures for drugs in the United Kingdom and the large number of unused medications recovered in a recent public health effort indicate the need for health education programs informing the consumer of alternatives to drug use. A seminar on this topic held by the Irish Medical Association indicated that participating physicians could be coerced by patients into prescribing drugs; patients are unlikely to consider alternatives to prescribed drugs as solutions to health problems; and doctors have been effective in reducing patient dependence on barbiturates and amphetamines. Alternatives to drug therapy have included a cardiac rehabilitation program and a program designed to increase the activity levels of the elderly. Both programs were well received by participants. Finally, consumers should be instructed about maintaining diets that may lessen the need for medications. Increased consumption of plant fiber may protect against constipation, diverticular disease, hiatus hernia, coronary heart disease, and gallstones, and may control the consumption and absorption of energy, thus decreasing a predisposition to obesity.

81-1874
The Prevention and Control of Periodontal Disease.
Sheiham, A.
Dental Health (London) 18(4):7-13, 16-20, 1979.

Preventive dentistry may be primary, preventing the occurrence of disease; secondary, slowing the progress of the disease; or tertiary, using dental technology for restoration and rehabilitation. Each preventive program should be evaluated to assess effectiveness under ideal clinical and field trial conditions, acceptability to the public, and cost effectiveness. To ensure the validity of clinical trials, preventive agents or procedures must follow a protocol that includes a study population exhibiting periodontal disease, a control group, evaluation criteria, and a field trial. Noncompliance with preventive regimens, one of the leading causes of dental disease, indicates a need for health education. A review of health education efforts by dentists suggests that (1) structural barriers, i.e., professional education in terms of therapy, repair, and restoration, with little emphasis on patient education, impede the provision of patient education; (2) periodontal disease should be considered a chronic disease and, consequently, changing the patient's health behavior should be a leading preventive and control measure; (3) ineffective

educational theories and methods are used by dentists; (4) dental information must be accurate, comprehensible, and effectively communicated; (5) socioeconomic and cultural backgrounds influence dental health behavior; and (6) dentists have an erroneous view of the public which hinders effective patient relationships. To change health behavior, a holistic approach is needed that concentrates on social and economic determinants of beliefs and behavior. Incorporating the Health Belief Model into dental health education could result in an effective program of preventive dentistry.

81-1875
A Patient Education System for a Rural Primary Care Centre.
Sullivan, M. E.
International Journal of Health Education (Geneva) 24(2):113-117, 1981.

A systems approach for integrating health education into a total health care delivery system has been developed using health education protocols (one-to-one or small group counseling sessions), patient education diagnosis forms, and documentation instruments as the chief integrating mechanisms. Developed for a community health clinic in Lowndes County, a low-income, rural community in Alabama, the approach provides basic health information to patients and the community, educates the patient on the means of adhering to medical treatment, and aids the patient and community in becoming consumer-oriented. The individual and small group counseling protocols were developed on the basis of interviews with the staff of a community clinic, a review of physicians' files, and a review of the 1970 census report. Individual and small-group counseling protocols were developed by a committee which included a doctor, nurses, a dentist, and a medical records librarian. The committee established five protocols: hypertension, diabetes, pregnancy and prenatal care, family planning, and venereal disease. A patient-oriented teaching guide is used which identifies behavioral objectives, educational content, and methods and materials to be used. The approach involves an educational diagnosis of the patient, implementation of the appropriate protocols, and documentation of the teaching experience and its results by using an appointment book, a log book, a disease index (consisting of 10 prevalent health problems for each disease), a patient index (consisting of statistics on the number of patients seen, the reason for education, and demographic data), and an information folder established for each patient. A similar system could be adopted by any community health organization.

81-1876
The Public, the Primary Physician, and Genetic Counselling.
Weitz, R.
Patient Counselling and Health Education 3(1):13-16, 1981.

Literature on variables that affect the likelihood that genetic counseling will be requested by clients or suggested by primary care practitioners is reviewed. Genetic counseling may be hindered by a lack of knowledge on the part of physicians and the public, psychological barriers such as fear of genetic disease and its social stigma, cultural values that stress fatalism, medical values that deemphasize clients' emotional needs and disease prevention and instead stress active intervention by the physician, and financial considerations. These findings suggest the need for research into (1) knowledge of and attitudes toward genetic diseases, disease counseling, and genetic screening among the general public; (2) variables affecting the public's response to genetic counseling and genetic screening programs in different sociodemographic communities; and (3) physicians' values systems and the effects of these systems on the use of genetic counseling. 18 references.

PROFESSIONAL EDUCATION AND TRAINING

81-1877
The Sex Education of Ministers.
Anderson, H. E.
In: The New Sex Education; The Sex Educator's Resource Book. Otto, H. A., ed. Chicago, Follett, p. 192-202, 1978.

Ministers share with other helping professionals the need for sex education that leads to an increased awareness of their sexuality, mastery of sex information, and development of appropriate methods to help people deal with sexual problems. Religious tradition has tended to equate sexuality with sin; thus, the sex education of ministers should begin by emphasizing the natural basis of sexuality. Other subtle tenets of the Judeo-Christian tradition, such as male supremacy, have hindered the development of an understanding of human sexuality among ministers and society at large. Because ministers are in a unique position as ethical spokesmen and community leaders to provide sex education, special attention needs to be given to enabling ministers to develop a process of ethical decision making in relationship to sex, which they can then utilize in helping people resolve the conflicts between religious

heritage and sexual drives. An outline for a human sexuality course in a theological seminary is appended. 7 references.

81-1878
The Reciprocal Benefits of Nutrition Student Participation in an Interdisciplinary Migrant Health Program.
Barnett, S. E.; Eden, W. E.; and McGill, J.
Journal of Nutrition Education 12(3):153-156, July-September 1980.

During 1974-76 graduate students in clinical nutrition and other advanced health science students in medicine, dentistry, nursing, and health education at the University of Colorado took part in the nutrition component of a migrant health program. After attending a 4-day orientation session, which consisted of seminars and lectures on primary health care, team development, transcultural issues, administrative relationships, and program goals, the students were separated into 15 primary health care teams and sent to rural areas. They provided services in nutrition appraisals and management, diet therapy, education, interdisciplinary communication, and records maintenance. The teams reviewed comprehensive physical and nutritional exams given to children, initiated treatment plans for specific children, and conducted parental education and inservice training for education and dietary staff. Sixteen clinical nutrition science students spent 183 student-weeks in the program, encountering 4,711 patients and providing 9,423 nutritional services. Increased serum vitamin A in the target-population children and evidence of increased community participation in nutrition activities suggest that the program was successful. The student logs provided useful information for determining cost effectiveness. 17 references.

81-1879
Patient Education Training. (Letter)
Bartlett, E. E.
Alabama Journal of Medical Sciences 18(1):14, January 1981.

The Department of Family Practice at the University of Alabama in Birmingham has implemented a residency training program in patient education and interpersonal skills development. The program is based on the premises that (1) patient education is part of high-quality medical care; (2) effective patient education requires a good physician-patient relationship; and (3) knowledge alone is not enough to change patient behavior. The program addresses social, educational, and economic factors that impede compliance with therapeutic regimens. During one clinical session per month, each resident is evaluated for interpersonal skills and application of patient education principles. The skills observed include the resident's ability to assess patient compliance; explain the disease and therapy; use patient education materials; and identify and influence the emotional, social, and environmental causes of compliance. Interpersonal skills such as establishing eye contact, providing appropriate reassurance, and using body language are also evaluated and strengthened. To reinforce clinical observations, the program offers monthly lectures on patient education, conducts chart audits to assure that patient education is documented, provides a patient education referral service, develops patient education materials, and publishes a national bimonthly patient education newsletter. A formal evaluation of the program is planned.

81-1880
Practical Approaches to Patient Teaching.
Bille, D. A., ed.
Boston, Little, Brown, 363 p., 1981.

Textual material to prepare nurses and other health professionals to act as patient educators is provided. The materials were developed from a continuing education workshop on a multidisciplinary approach to patient education. Main areas covered include the structure of patient teaching, patient-teaching activities, and roles and settings for patient teaching. Specific topics include a comprehensive system of patient education, development of a philosophy of patient teaching, the patient's right to know, the teaching-learning process, approaches to health care among three American minorities, family-centered patient education, discharge planning and patient teaching, program evaluation, and quality assurance. Other topics covered are cost-benefit and cost-effectiveness analysis, financial sources, media, computerized hospital information systems, the role of the patient educator, the role of the director of nursing services, physician support, the role of the pharmacist, the role of the librarian, education of critically ill patients, and patient teaching in the pediatric and psychiatric units. Numerous references and appendices.

81-1881
The Health Educator as Death Educator: Professional Preparation and Quality Control.
Crase, D.
Journal of School Health 50(10):568-571, December 1980.

At present, only 38 percent of all health teachers have studied death and dying during their training, and comprehensive university programs to prepare death educators do not exist. Organizations that offer opportunities for death educators include the Center for Death Education and Research of the University of Minnesota, the Foundation of Thanatology in New York City, and the Forum for Death Education and Counseling in Arlington, Virginia. The latter has committed itself to establishing means of professional certification or licensing. Teachers and counselors may elect to engage in self-development activities available through convention programs, workshops, or seminars. Competencies useful to death educators include an understanding of the dynamics of death as an integral part of the total personality, a command of the language of death, familiarity with the sequence of life stages, awareness of changes in social perceptions of death, ability to communicate with students, skill in counseling and crisis intervention techniques, knowledge of pertinent resources, and understanding of interdisciplinary techniques and evaluation strategies. 12 references.

81-1882

Health Education: Prevention Training for Professionals.

Farthing, C.

Rockville, Md., Department of Health, Education, and Welfare, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, Office of Communications and Public Affairs, 8 p., (1979).

A program offering skill-building workshops in preventive mental health education is conducted by the department of psychiatry at the University of North Carolina. The target groups for the program are key individuals in school systems, mental health centers, departments of social services, correctional facilities, and public health nursing settings. During a 12-month period, four 2.5-day workshops are offered in each of the four North Carolina Department of Human Resources regional areas. The workshops focus on consultation skills, affective education techniques, and parent education strategies. The primary objective is to teach skills to community professionals who work with school-age children and their parents. A questionnaire is administered before the workshop and after each topical area in the program is covered to assess knowledge and skill levels of participants. A followup questionnaire is administered to participants 3 months after the end of each workshop. The ability of participants to train other community professionals is also assessed 3 and 6 months after the end of each workshop. Evaluation results from five workshops indicate that participants' knowledge and skill levels changed significantly and that 10 to 20 percent of the participants undertook inservice educational efforts in their own communities. Copies of evaluation instruments and a bibliography are appended. 20 references.

81-1883

The Nurse's Role in Hypertension Control.

Grim, C. M. and Grim, C. E.

Family and Community Health 4(1):29-40, May 1981.

In 1975, the National High Blood Pressure Education Program, in cooperation with the American Nurses Association and the National League for Nursing, sponsored a task force on the role of the nurse in high blood pressure control. The task force recommended emphasizing high blood pressure in nursing curricula, preparing more nurses to provide primary care for patients with uncomplicated hypertension, and including nurses in research related to the care of hypertensive patients. The task force also outlined standards for cardiovascular nursing practice that covered collection of data on patients' health status for nursing diagnosis, formulation of goals, development of an intervention plan based upon the goals, implementation and evaluation of the nursing plan, and periodic reassessment of the patient's situation. Nursing functions can be organized into clinical service, research, education, and community activities. Regardless of the clinical setting, the nursing plan to control hypertension involves a sound approach to screening, evaluation and treatment, a patient education program, and a hypertension-control monitoring system. Nurses involved in hypertension control should be familiar with the principles of the Health Belief Model. Settings in which nurses are needed for hypertension control efforts include acute care settings, schools, worksites, other community settings, professional education settings, and physicians' offices. 24 references.

81-1884

The Importance of the Health Education Role of the Environmentally Qualified Person. A Definition by Behavioral Learning Objectives.

Jolly, P. W. 119 p., June 1977.

Available from: ERIC; Order No. ED-187 535.

To act as a health educator, the environmental health officer (EHO) should have formal training in health education. To communicate environmental health innovations to the public, the EHO must understand how messages are encoded, conveyed, decoded, remembered, and forgotten. A review of the sociobehavioral determinants of compliance with health recommendations, as developed in the Health Belief Model and value expectancy theory, de-

monstrates the pertinence of these theories to the work of the EHO. The EHO should be competent in analyzing tasks, establishing area profiles, planning programs, lecturing to and leading discussions with small groups and school classes, providing face-to-face counseling, drafting press releases, preparing public service announcements, referring clients to community resources, and evaluating educational interventions. Application of the systems approach to health education programs is discussed. 20 references.

81-1885
Prospective Teachers' Knowledge About Alcohol and Its Use.
Kenney, P. W.
Journal of Alcohol and Drug Education 22(3):49-63, Spring 1977

A study involving 435 of the 668 students enrolled in basic professional courses for preservice teachers at the University of Maine at Orono during spring 1975 attempted to determine how much preservice teachers knew about alcohol and its use. A revised version of the Passey and Pennington Scale for the Assessment of Knowledge Concerning Alcohol and Its Use was modified and administered to the subjects. Analysis of the responses indicated that (1) females scored higher than males on total knowledge indices and seven of eight knowledge scales; (2) male subjects scored higher than females on the scale assessing knowledge of the manufacture of alcoholic beverages; (3) subjects intending to teach at the elementary level scored higher than those intending to teach at the secondary level on indices of knowledge of treatment procedures for alcoholism; and (4) prospective secondary-level teachers had significantly higher scores than their elementary-level counterparts on indices of knowledge of the manufacture of alcoholic beverages. A profile emerged of the prospective male teacher as less knowledgeable about alcohol and its use than the prospective female teacher. Since other research has indicated that secondary prevention may be the key to mitigating problems associated with alcoholism among the young, more research is needed into ways to increase the knowledge level of teachers via preservice and inservice programs. 13 references.

81-1886
Inappropriate Nutrition Education in the Villages. (Letter)
Morley, D. and Chiang, C. Y.
Lancet 1(8213):209, January 24, 1981.

Six newsletters distributed to village-level nutritionists in developing countries were examined to determine how much emphasis is placed on increasing children's protein intake. The newsletters included one international newsletter and newsletters from Ethiopia, Liberia (two), Bangladesh, and India. All editions from 1975 to 1980 were evaluated; a total of 155 articles, 25 of which referred to protein-energy malnutrition, were reviewed. As expected, most articles stressed the importance of protein and ways of incorporating more protein-rich foods into local diets. Only 4 of the 25 protein-related articles referred to the bulk of the diet; another 4 referred to energy requirements of the weaning child. Because newsletters are an important source of information for third-world nutritionists, they should reflect current nutritional theory, i.e., they should stress energy needs as opposed to protein needs when discussing diets for children. 2 references.

81-1887
Washington State Cancer Conference.
Nickerson, C. J., Shively, G.; Dolan, B.; and Sparling, V.
Health Education 9(6):15-16, November-December 1978.

The Washington State Cancer Education Conference brought together State, local, and regional education leaders and representatives from community organizations, health agencies, and a regional cancer center. Funded by the National Cancer Institute and implemented by a group of State representatives who attended the Colorado Cancer Education Conference, the conference was intended to improve awareness of cancer treatment, rehabilitation, and prevention and to obtain a commitment from participants for support of an increased effort to improve the quality and quantity of cancer education in State schools. The program included a minicourse for nonmedical professionals on cancer, small group discussions and presentations by educators to inform participants of education about cancer, and lectures and discussions on programming and use of available resources. Participants were asked to make a written commitment to fulfill the objectives of the conference. A followup survey implemented 6 months after the conference revealed that a broad range of personal and organizational commitments had been fulfilled. Numerous cancer-related activities continue to be implemented as a result of the conference.

81-1888
Staff Development Program Leads to Patient Development Program.
Schwartz, J.
Journal--American Health Care Association 3(5):36-37, September 1977.

The inservice coordinator at the Flushing Manor Nursing Home and Care Center in Flushing, New York, coordinated, planned, and implemented a training program in sexuality and aging for 400 employees. The coordinator enlisted the help of representatives of the nursing, social services, rehabilitation, recreation, dietary, housekeeping, and administrative departments. The program addressed the biological and physiological changes that occur during aging, the sexual and emotional needs of the elderly, social and psychological factors that influence sexual attitudes and expression, and supportive staff responses. Teaching methods included role playing, lectures, group discussions, and films and other audiovisual aids. A peer discussion program for residents of the health facility was subsequently initiated and proved successful. During the program, residents recommended that (1) one floor or section be designated for those who wish to live together; (2) sexual counseling be available; (3) more educational aids related to sexuality be available; and (4) resident and family development programs be planned on other topics. 3 references.

81-1889
The Illusory Partitions Between School, Community and Hospital Health Education.
Sechrist, W. C.
Health Values: Achieving High Level Wellness 4(6):266-268, November-December 1980.

Defining and preparing health education specialists by employment locations (school, community, or business) has inhibited the development of certain conceptual formulations that are necessary for advancing the state of the art. A useful alternative to categorizing health educators according to their place of employment is to focus on the skills all professional health educators need to serve the public. Professional preparation programs could be designed with an emphasis upon primary, secondary, and tertiary educational intervention skills. All health educators will encounter people who are experiencing high levels of health, people who are asymptomatic but at risk, people who are symptomatic but not complying with treatment regimens, and people who are undergoing treatment. Health educators have professional responsibilities that require expertise in dealing with clients in each category. 6 references.

81-1890
Dental Hygiene Students' Diets: Before and After a Nutrition Course.
Zawada, K. M.
Dental Hygiene 55(8):17-21, August 1981.

A study of 14 senior dental hygiene students was designed to assess their self-reported diets before and 1 year after attending a required nutrition course at the University of Missouri, Kansas City, School of Dentistry. The students kept formal 5-day diet diaries, which were examined to determine intakes of iron, calcium, vitamins A and C, and sugar. Mean nutrient values were calculated and compared with the dietary allowances recommended by the National Research Council. Results showed no statistically significant differences in the intake of iron, calcium, sugar, or vitamin A. Vitamin C intake increased significantly. Research should be undertaken to compare the dietary practices of dental hygienists with those of the general population. 13 references.

REGULATION, LEGISLATION, AND ADMINISTRATION

81-1891
Health Promotion. (Editorial)
Harris, R.
Australian Dental Journal (Sydney) 24(6):421-423, December 1979.

The Australian Health Services Advisory Council, representing the Australian Dental Association, has proposed the establishment of a National Health Promotion Council. The council would seek to encourage greater individual interest in health standards; divert more scientific effort to developing methods for changing individual lifestyles; ensure that industrial health hazards are progressively reduced and eliminated; and reduce injury and death from traffic accidents. The need to establish such a council is underscored by rising annual health care costs. In addition, the increase in population and the country's economic growth have increased demand for health services and for medical facilities and personnel. The dental profession has made a positive contribution to improving nationwide oral health, especially among children, by maintaining a definite policy of advocating the universal use of fluorides and stressing the value of good oral hygiene and a properly balanced diet. The council's philosophy can be successful if community health education is given priority and health professionals give greater emphasis to health promotion. 2 references.

81-1892
Dental Public Health and Community Dentistry.
Jong, A., ed.
St. Louis, Mo., Mosby, 290 p., 1981.

The social role of dentists is changing from individual rehabilitative clinical services to an integrated member of a preventive health team concerned with early diagnostic services. The role of consumer groups, the proliferation of third-party payment programs, and the expansion of dental auxiliaries are affecting the practice of dentistry. Topics of interest in this area include dental public health, social factors affecting the practice of dentistry, the role of auxiliaries in dental care, Medicaid as an example of governmental involvement in dental care, epidemiology of dental disease, prevention of dental disease, dental health education, formulation of community programs, the role of the consumer in dental care, biostatistics, program evaluation in health care, research in community dentistry, team management in dental practice, stress in dental practice, and national health policy in the area of dental health. Numerous references.

81-1893
Effects of Austria's Smoking and Health Report.
Kunze, M.
World Smoking and Health 5(2):43-44, Summer 1980.

Smoking among Austrian citizens has declined considerably since 1974. In that year, the Secretary of Health and Environmental Protection published the country's first report on smoking and health, and numerous Federal and private organizations joined the antismoking movement. In addition, the use of filters has increased significantly, and the tar and nicotine content of cigarettes has dropped. In 1979, the Government initiated a campaign to provide information on minimal intervention techniques to physicians, establish a nationwide program to screen smokers for tobacco-related disease, develop health education programs for high-risk populations, ban tobacco advertising on radio and television, and pass a law requiring that all cigarette packages be labeled with health warnings. In the future, the Government should attempt to control production and distribution of tobacco products, establish standards for tobacco products, set diminishing tar and nicotine yields for cigarettes, and institute a variable cigarette tax tied to tar and nicotine content.

81-1894
Papua New Guinea's National Food and Nutrition Policy.
Lambert, J.
Food and Nutrition (Roma) 6(1):28-33, 1980.

Over the past 4 years, a public awareness campaign in Papua New Guinea has succeeded in focusing national attention on nutrition problems, particularly those affecting children. Publication in 1947 of the results of a survey of food consumption patterns in five villages encouraged the Department of Agriculture to increase the country's food supply, but the Department's emphasis on cash crops, such as coffee, coconuts, and cocoa, undermined these efforts. After independence was achieved in 1975, the Government published the 1976 national development strategy, which outlined a development philosophy emphasizing increased domestic food participation and improved nutrition. A working group developed a food production and nutrition policy in 1977 designed to improve the nutritional status of various target groups and to reduce dependence on imported foods. In response to a 1978 survey of the nutritional status of the nation, an attempt has been made to increase the supply of food in urban and village areas. The main effort of the new policy is a national nutrition education campaign operating through schoolteachers, agricultural extension workers, and health workers. A number of simple, practical messages are being disseminated via radio, lectures, posters, leaflets, plays, and other media. The program also has a school lunch component. Successful efforts of the program have included prohibition of the unrestricted sale of baby-feeding bottles; institution of a code of ethics for manufacturers of snack foods; and implementation of specific local programs, particularly for areas involved in resettlement.

81-1895
Minor Analgesic Abuse: The Slow Recognition of a Public Health Problem.
Murray, R. M.
British Journal of Addiction 75(1):9-17, March 1980.

Increased consumption of minor analgesics such as aspirin and phenacetin was recognized as a health concern in the early 1950's when analgesic-induced kidney disease emerged in Switzerland. Scandinavia, North America, Britain, and particularly Australia reported increased analgesic-induced kidney disease during the 1960's. Initially, the medical profession was skeptical about these reports because of a lack of epidemiological evidence and knowledge as to which analgesic--phenacetin or aspirin--caused the kidney damage. Confusion also existed over the minimum analgesic dosage necessary to induce kidney damage. Physicians were unable to accept the fact that analgesic abuse was due to patient dependency (phenacetin can have psychotropic effects). In addition to certain psychiatric disorders, analgesic abuse may also induce gastrointestinal disorders; peptic ulceration; and

neurologic manifestations such as hallucinations, confusion, coma, tinnitus, and deafness. Preventive measures include withdrawing phenacetin from classification with common analgesics; encouraging consumers to change attitudes toward analgesic taking; and ensuring that advertisements stress pain-relieving properties rather than tension-relieving or mood-enhancing effects. 40 references.

81-1896
New Warnings on the Way for Oral Contraceptives.
Zimmerly, J. G.
Journal of Legal Medicine 5(2):23-24, February 1977.

The Food and Drug Administration (FDA) plans to update warnings on oral contraceptives to include new medical complications discovered since 1970. The FDA's proposal would require pharmacists to give a detailed brochure explaining the pill's benefits and risks to every patient receiving a new oral contraceptive prescription or a refill. The brochure would also compare the benefits and risks of oral contraceptives with those of other methods. Drug companies would be required to expand the patient insert included in every pill packet and to make major revisions in information available to physicians within 120 days of such changes. In 1975, a survey of women using the pill since 1970 indicated that (1) 90 percent had received and read an insert supplied with a prescription; (2) 80 percent read the insert when they started using the drug; (3) 10 percent read the insert every time a new supply was purchased; (4) 50 percent thought that directions for use were the most important segment of the insert; (5) few users knew that they should notify their doctors about any discomfort, and even fewer knew that they could obtain a booklet with additional information; and (6) most users wanted additional information on drug interactions, side effects, warnings, and other precautions. 2 references.

RESEARCH AND EVALUATION

81-1897
First National Sickle Cell Educational Symposium, May, 1976, St. Louis, Missouri. Proceedings.
Bethesda, Md., National Heart, Lung, and Blood Inst. (DHEW, NIH), Sickle Cell Disease Branch (DHEW Publication No. (NIH)78-1084), 198 p., (1978).

The First National Sickle Cell Educational Symposium, held in St. Louis in May 1976, was sponsored by the National Heart, Lung, and Blood Institute and by the Office of Continuing Education of the Washington University School of Medicine in St. Louis. The traditional presentation of papers was replaced by a program organized around "grand rounds" on two case studies. One case involved an adult, the other a child. Following the presentations of the patients' case histories and clinical findings, specialists in different fields discussed the cases from their different perspectives. Specialists presenting papers on the child's case included a geneticist, a hematologist, a pediatrician, a cardiologist, a nurse, and a social worker. Specialists presenting papers on the adult's case included an internist, a hematologist, an ophthalmologist, and an endocrinologist. Minisymposia were held on clinical management, genetic counseling, educational techniques, and current research. Formal presentations were given on parent education, the history of the National Sickle Cell Anemia Program, and the educational aspects of sickle cell programs. Panels also addressed the international perspective on the disease and sickle cell services as part of comprehensive health. A list of conferees is appended.

81-1898
Study of Food-Habits, Food Practices and Taboos in Bangladesh: Their Implications in Nutrition Education.
Begum, R.; Hussain, M. A.; Abdullah, M.; and Ahmad, K.
Bangladesh Medical Research Counsel Bulletin (Dacca) 5(1):1-13, June 1979.

A retrospective study was undertaken to determine the food habits, taboos, and practices among 381 mothers selected randomly from 12 villages in Bangladesh. The questionnaire used to elicit information included sections on demography, food practices and distribution of food within the family, food habits and taboos during pregnancy and lactation, and attitudes and customs concerning the feeding of sick children. After pretesting in a village, the questionnaire was used by a single interviewer to gather information from all 12 target villages over a 1-year period. Data collected indicated that undesirable food taboos and practices, maldistribution of food, lack of understanding of the nutritional needs of vulnerable groups, and unhealthy cooking practices were widespread in this rural area. To remedy these problems, effective nutrition education, which should be combined with a general education program for women, is needed to improve cooking practices and eating patterns and to improve food distribution practices among families. 13 references.

81-1899
Children's Smoking: A Review.
Bewley, B. R.
World Smoking and Health 2(2):35-40, Fall 1977.

Studies of children's smoking behavior generally examine prevalence, health effects, and psychological and social characteristics of the smoker. Prevalence studies have concentrated on the relationships between cigarette smoking rates and age, sex, types of schools attended by the children, and urban versus rural settings. Though few in number, studies on health effects have reported differences in respiratory symptoms (smokers cough more and produce more phlegm) between smokers and nonsmokers. Although studies on the psychological and social characteristics of young smokers have reported conflicting results, correlations between smoking and poor academic achievement have been reported. Peer pressure and family influences have received much attention as causes of smoking onset. One of the major reasons that antismoking education has been unsuccessful is that it has not been presented to children in a manner that ensures that they understand the effects of smoking on their health. Also, children do not see themselves as smokers, since they smoke less than adults.

81-1900
Pilot Study Examining the Motivational Effects of Maximal Exercise Testing to Modify Risk Factors and Health Habits.
Bruce, R. A.; DeRouen, T. A.; and Hossack, K. F.
Cardiology (Basel) 66(2):111-119, 1980.

A questionnaire was mailed to 2,892 men 35 to 65 years old who had undergone treadmill exercise testing. The study was designed to assess whether exercise testing could motivate patients to modify certain risk factors and health habits. Sixty-nine percent of the men responded to the questionnaire, and 63 percent of the respondents indicated that they modified at least one risk factor or health habit and that this change was attributable to the exercise test. Participants with abnormal functional aerobic impairment, as demonstrated by the exercise test, were more likely to be motivated to change their lifestyles. The study suggests that exercise testing may encourage people to modify coronary risk factors and health habits. A study with a more thoroughly controlled design, involving an experimental population exposed to counseling, clinical examination, and exercise testing and a control population exposed to the same counseling and clinical examination but no exercise testing, would provide more definitive data. 14 references.

81-1901
The Relationship Between the Health Belief Model and Compliance of Persons With Diabetes Mellitus.
Cerkoney, K. A. B. and Hart, L. K.
Diabetes Care 3(5):594-598, September-October 1980.

Six to twelve months after attending diabetes education classes at a community hospital, 30 insulin-dependent diabetics were interviewed in their homes in an effort to assess the value of the Health Belief Model. Self-reports and direct observation were used to measure the patients' levels of compliance with their insulin administration, urine testing, diet, hypoglycemia management, and foot-care prescriptions. All patients were complying with at least 36 of the 61 points measured, and over 50 percent indicated compliance with at least 42 of the points. However, only 7 percent complied with all 45 points considered necessary for control of the disease. The group was most compliant with insulin administration and least compliant with urine testing. The relationship between the patients' health beliefs regarding their disease and compliance was also measured. Subjects who perceived their diabetes to be serious, and responded to cues, tended to be more compliant with their regimen than were those who did not have this perception. Yet, health belief motivators could only account for about 25 percent of the variation in the compliance levels of the sample, and a much higher level of correlation would be necessary to be able to use these motivators as reliable clinical predictors. 48 references.

81-1902
Health Education and the Teacher's Role.
Charlton, A.
International Journal of Health Education (Geneva) 24(2):102-112, 1981.

A survey of 672 students and 160 tutors in 13 teacher-training establishments in England was conducted to determine their views of the role of the teacher, the aims of health education, and their involvement with the discipline. Results indicated that 53 percent of the students and 36 percent of the tutors viewed the primary role of the teacher as helping pupils make the most of their talents; 28 percent of the students and 12 percent of the tutors thought that the teacher's primary role was teaching basic skills. Primary grade teaching candidates valued skills development more than talent development, while tutors favored the latter. Provision of information was most often chosen as the goal of health education by secondary school candidates and tutors, while primary grade teaching candidates selected influencing attitudes as the major goal. One-third of the students surveyed did not expect to teach health education.

81-1903
Changes in Attitudes Towards Drug Educators as a Function of Communicator Sex and Role.
Cotton-Huston, A. L. and Baum, C. S.
Journal of Drug Education 10(3):249-256, 1980.

A study involving 130 female and 117 male seventh-graders from 3 junior high schools in West Hartford, Connecticut, assessed changes in attitudes toward drug educators as a function of students' beliefs concerning the educators' role. Each of six drug educators was labeled as an ex-addict for one group of students and as a specialist for another group. The sex of the subject, sex of the educator, and role of the educator were combined in a 2-by-2-by-2 factorial design. The labels for the educators were suggested by two classes of students drawn from a population comparable to that actually sampled for the study, and the educators participated in role playing to familiarize themselves with their roles. Students were asked to rate drug educators using semantic differential scales before and after the 45-minute drug education presentation. Data from the questionnaires indicated that (1) male ex-addicts were viewed more positively in terms of evaluation (good-bad, fair-unfair, honest-dishonest, and valuable-worthless) than female ex-addicts; (2) female specialists were viewed more positively in terms of evaluation than male specialists; and (3) female specialists were viewed more positively in terms of potency (likeable-nonlikeable, strong-weak, friendly-unfriendly, smart-stupid) than male specialists. Results suggest that the students had sex-stereotyping tendencies, in that they viewed addiction as more unacceptable in women than in men and social work as more appropriate for women than for men. Thus, it appears that women would be effective specialist educators at the junior high school level. 15 references.

81-1904

Evaluating Printed Health Information for Consumers.

Dalton, L. and Gartenfeld, E.

Bulletin of the Medical Library Association 69(3):322-324, July 1981.

The Community Health Information Network, a cooperative network of libraries which was created in 1977 by Mount Auburn Hospital in Cambridge, Massachusetts, and six public library systems in Mount Auburn Hospital's catchment area have established public libraries as the primary access points for consumers and community-based professionals seeking health information. In December 1978, the network held a series of meetings of health care professionals to examine how these providers assess health information in print and other formats. Selection criteria considered included accuracy, currency, point of view, audience level, scope of coverage, organization, style, and format. The evaluators agreed on the need to review any materials giving advice the public might adopt. 3 references.

81-1905

Smoking Cessation Among Patients With Chronic Obstructive Pulmonary Disease (COPD).

Daughton, D. M.; Fix, A. J.; Kass, I.; and Patil, K. D.

Addictive Behaviors (Oxford) 5(2):125-128, 1980.

A study involving 107 pulmonary rehabilitation patients was designed to assess 9 variables associated with smoking cessation among patients with chronic obstructive pulmonary disease (COPD). Approximately 67 percent of the patients were ex-smokers at the time of admission into the study. Variables assessed via questionnaires included psychosocial factors, marital status, occupational status, age, educational level, intelligence, tendency towards depression, and smoking history rendered in pack-years. Discriminant analysis revealed that psychosocial factors were significantly related to the ability to stop smoking before hospitalization and that smoking history significantly differentiated smokers from ex-smokers 5 to 54.5 months after hospitalization. None of the other variables were significantly associated with smoking cessation, and even the two significant variables were not able to separate smokers from ex-smokers beyond base-rate expectations. While most smokers with COPD did quit smoking, those who failed to do so before hospitalization were likely to continue the habit indefinitely. 8 references.

81-1906

Attitudes and Smoking Habits of Dentists in Victoria.

Dodds, A. M.; Gray, N. J.; Hill, D. J.; and Rankin, D. W.

Australian Dental Journal (Sydney) 24(3):143-145, June 1979.

A representative sample of 350 dentists practicing in Victoria, Australia, was surveyed by mail to assess an educational program informing dentists of their role in the detection of oropharyngeal cancer. Data from the 305 returned questionnaires indicated that (1) 23 percent of the respondents smoked; (2) health hazards of smoking figured strongly among the reasons given by ex-smokers for breaking the habit; (3) beliefs about the medical effects of smoking correlated positively with medical evidence; (4) 43 percent of the dentists encouraged all patients to give up smoking; (5) 29 percent encouraged patients suffering from a smoking ailment to give up smoking; (5) 21 percent encouraged patients to give up smoking only when such advice was sought; and (6) 7 percent thought they should not get involved in discussions with patients about their smoking habits. Though dentists smoked less than the general population, they smoked more than physicians. Overall, dentists in Victoria seemed generally well informed and capable of acting as role models. 6 references.

81-1907
Let's Look Before We Leap: The Cognitive and Behavioral Evaluation of a University Alcohol Education Program.
Engs, R. C.
Journal of Alcohol and Drug Education 22(2):39-48, Winter 1977.

In September 1975, a controlled study involving 83 students at Indiana University assessed the effectiveness of an alcohol education program. The program was based on needs assessment of the target audience, the latest philosophies of alcohol education, educational methodologies that have been shown to produce behavior change, and use of peer counselors. Following a 13-minute film on the history of the production and use of alcohol and myths about alcohol, small-group discussions based on five values-clarification exercises were held. Group facilitators received 8 hours of training in communication skills, leadership skills, values clarification, referral, and alcohol use. Data from questionnaires indicated that increased knowledge levels exhibited by subjects had no significant effect on their alcohol use. Longitudinal studies are needed of the effects of a variety of educational interventions on alcohol use. 20 references.

81-1908
Current Psychological, Social, and Educational Programs in Control and Prevention of Smoking: A Critical Methodological Review.
Evans, R. I.; Henderson, A. H.; Hill, P. C.; and Raines, B. E.
Atherosclerosis Reviews 6:203-245, 1979.

Currrent psychological, social, and educational programs designed to control or prevent smoking are reviewed. General methodological problems include poor sampling techniques; use of attitudes, knowledge levels, and self-report behaviors as the primary independent variables; failure to employ adequate statistical analysis tools; failure to examine long-term recidivism; and failure to utilize control groups or to use appropriate control groups. Specific examination of a representative sample of public information campaigns, direct cessation programs, school antismoking programs, and legislative action designed to help smokers quit indicates that focusing primarily on programs to persuade already addicted smokers to stop smoking can have only limited value. This situation is largely due to the regression effect that leads to recidivism. This conclusion and data from public information campaigns and school programs designed to prevent smoking suggest that the best way to reduce the number of smokers is to influence preaddictive smokers and nonsmokers to refrain from smoking. Programs for intervention with adolescents must replace fear-arousal and information-provision strategies with strategies emphasizing resistance to peer pressure and to other environmental influences that encourage them to smoke. 157 references.

81-1909
Completion of Referrals for Hypertension Screening.
Flynn, B.
Physician's Patient Education Newsletter 3(6):1-3, December 1980.

Five recent, randomized experimental studies that examined referrals from community hypertension screening programs to medical treatment services are reviewed. The common element effective in all studies was personal contact with an individual assigned specifically to deliver educational messages. The effect appeared to be independent of the length of contact with the educator, use of other media, or specific content of the contact. Simple and inexpensive forms of followup, such as mail and telephone reminders, were also effective. Individuals referred and given appointments at specific times, with a specific person, and within a short time of the date of referral are more likely to complete their referrals. 17 references.

81-1910
The Need for Cooperative Health Education: Some Survey Findings.
Ford, A. S. and Ford, W. S.
International Journal of Health Education (Geneva) 24(2):83-94, 1981.

A literature review and an analysis of two recent population surveys reveal health knowledge, attitudes, and practices among consumers of health care and indicate the effectiveness of various health education strategies. Articles appearing in health and health education journals during the 1970's emphasized preventive medicine, consumer education, individual responsibility for health care, patient compliance strategies, and attempts to change social and environmental conditions that result in disease. In 1978, a State health education resource center (one of a system of regional health centers) conducted 2 surveys in an 18-county area in northwest Florida: a population-based survey of 321 households, and a mail survey of 103 primary care physicians. The household survey assessed health knowledge, attitudes, and practices in the region; the other assessed the extent of health education provided by physicians. Results indicate the need to develop health intervention schemes outlined by Modolo, who stressed that health education ought to be a cooperative enterprise

involving individual responsibility, strong support for self-help groups and school-based programs, sustained and effective coverage by the mass media, and open communication among providers, educators, and consumers. Physicians surveyed felt that primary responsibility for health education should be delegated to physicians, professional health educators, and public health personnel. Placing the data within Modolo's framework suggests the need to broaden the idea of holistic health to include all sectors of the community. 14 references.

81-1911
Evaluation of Dental Health Education Programs.
Freed, J. R. and Matthias, R. E.
Journal of Public Health Dentistry 40(1):39-46, Winter 1980.

A literature survey was conducted to assess methods used to evaluate dental health education programs. The literature search, which was restricted to dental health education programs that had intervention strategies to effect behavioral changes and that included an evaluation component, yielded 36 articles from 14 professional journals published from 1971 to 1975. Each of the programs was analyzed to provide an understanding of the demography of the target population, site of the study, geographic location of the study, type of educational program, study design, response measured, and measurement instruments used. Results indicated that (1) reporting of demographic information was inadequate; (2) there was a great deal of diversity in program design; (3) sample sizes tended to be small, though the size did not seem to affect statistical significance; (4) some form of control group was used in most of the studies; (5) followup measures were generally inadequate; (6) behaviorally related outcomes were the object of measurement more often than outcomes related to knowledge, beliefs, and attitudes; and (7) measurement instruments used to assess responses were deficient. Overall, there is a lack of focus and standardization among dental health education studies that hinders the development of cumulative evidence. Thus, the application of research findings to policy decisions in dental health education may be hampered more by the lack of reliable findings than by the lack of application of these findings. 14 references.

81-1912
The Right Questions: Evaluation Tools for Youth Alcohol Abuse Prevention.
Hathaway, B.
Rockville, Md., National Clearinghouse for Alcohol Information, National Inst. on Alcohol Abuse and Alcoholism (DHHS, ADAMHA), 4 p., 1980.

An annotated list of eight survey instruments for gathering information about adolescent alcohol knowledge, attitudes, and drinking patterns is provided. The instruments can be used to conduct needs assessments and gather base-line data for evaluating prevention programs. Many of the instruments have been designed and used in projects funded by the National Institute on Alcohol Abuse and Alcoholism. Ordering information and prices are included.

81-1913
Proficiency in Performing Breast Self-Examination.
Howe, H. L.
Patient Counselling and Health Education 2(4):151-153, 1980.

One hundred and sixty-one women practicing breast self-examination (BSE) were tested for their competence in the BSE technique and for their ability to detect lumps in a silicone breast model. Fewer than 25 percent of the women performed all components of the examination correctly. Most were able to find four of the seven lumps in the silicone model. The measurements commonly used to evaluate BSE efficacy (the length of time that BSE has been practiced, or the frequency of the practice) were not associated with BSE competence in the study subjects. The subjects' descriptions of how they performed their self-examination (what part of the hand was used, the type of motion employed, or the firmness of pressure) were not associated with the number of lumps detected. However, the number of BSE components that were completed correctly correlated positively with the number of lumps detected. Improved methods of instruction to increase proficiency in BSE must be undertaken before the effectiveness of this technique as a means of early detection can be accurately ascertained. 7 references.

81-1914
Hypertension in Secretariate Population of Bangladesh.
Islam, N.; Janan, F. A. J.; Chowdhury, N. A.; Ahmed, Z.; and Mathura, K. C.
Bangladesh Medical Research Counsel Bulletin (Dacca) 5(1):19-24, June 1979.

In Bangladesh, 8,172 members, or 98.6 percent, of the Secretariate (government service) population were screened for elevated blood pressure. Approximately 1,100, or 13 percent, had diastolic blood pressure readings of 90mm of mercury or above, and 4 percent had diastolic blood pressures of 95mm or above. For more than 66 percent of the latter group, high blood pressure had been

undetected, which indicates that a large part of the hypertensive population remains undiagnosed and untreated. These findings suggest that the incidence of hypertension in Bangladesh is underestimated and that symptomatic hypertension can be reduced by emphasizing that hypertension control can prevent cardiovascular and cerebrovascular complications. In addition, a large-scale survey among various groups of the population should be conducted to determine the extent of the hypertension problem as a background for a public education program. 1 reference.

81-1915

Education, Parental Interest, and Health Perceptions and Behavior.

Mechanic, D.

Inquiry; British Journal of Accident Surgery (Bristol) 17(4):331-338, Winter 1980.

A 1977 followup of a 1961 study involving 350 students attending 7 schools in Madison, Wisconsin, was conducted to assess how children's health is affected by education, parental interest in the child, parental expectations of the child's responsibility, parental restrictiveness, health behavior modeling by parents, and self-esteem levels in parents. Of the 350 children involved in the 1961 study, 333 were located in 1977, 6 had died, and 11 could not be found. Of those located, 302 completed detailed questionnaires on health attitudes, values, experiences, and behavior. The data indicated that (1) the effects of education on various health behaviors remained positive even when various intervening variables such as parental interest and self-esteem were taken into account; (2) some aspects of the energized family (families with frequent and varied interaction among members), such as parental interest, contributed to good health behavior, but these contributions were independent of education; (3) the caring qualities of parental interaction seemed to be better predictors of health behavior than global concepts such as the energized family; and (4) parental modeling behavior showed no relation to health responses. Future research should attempt to identify the specific aspect of education that contributes to health. Numerous references.

81-1916

Role of Health Education Among Services Rendered By Dental Personnel in Finland.

Murtomaa, H. and Ainamo, J.

Community Dentistry and Oral Epidemiology (Copenhagen) 5(4):164-168, July 1977.

Interviews were conducted in June 1973 with 505 people representing the Finnish population 15 years old and above to determine the quantity and origins of dental health education information. Subjects were asked about the nature of their last dental visit, dental care received over the past year, information sources trusted most, the effect of information on personal habits, and the sufficiency of information received about dental home care. The interviews revealed that (1) tooth extraction was the most frequent activity performed during the last visit to the dentist; (2) tooth filling was the second most frequent activity; (3) periodontal treatment and teaching about home care were rarely mentioned as being provided by the dentist; (4) radio and television were the most frequently mentioned sources of information; (5) subjects were skeptical of information received via the broadcast media; (6) dental service personnel were not major sources of information; and (7) most subjects thought they had not received enough information on home care. 23 references.

81-1917

Workshop on Nutrition Education Research: Applying Principles from the Behavioral Sciences; Cornell University, Ithaca, N.Y., April 28-30, 1980; Proceedings.

Olson, C. M. and Gillespie, A. H., eds.

Journal of Nutrition Education 13(1-Suppl. 1):118 p., 1981.

The Workshop on Nutrition Education Research at Cornell University on April 28-30, 1980, promoted the application of theories and research from behavioral sciences to nutrition education. Topics addressed during the workshop included anthropological contributions to nutrition education research, nutritional anthropologists and nutrition educators, communication theory and nutrition education research, application of communication theory in nutrition research, psychology and nutrition education, sociopsychological strategies and their rationale for changing people's eating habits, social psychological perspectives and applications to nutrition education research, assessment of nutrition-related attitudes and beliefs of teachers, a Piagetian-based study of children's thinking about food and eating, the Q-sort technique applied to nutrition attitudes investigation, and a computer-assisted instruction model for renal diet therapy. Numerous references.

81-1918

Continuity of Care and Poisoning Prevention Education.

Phillips, W. R. and Little, T. L.

Patient Counselling and Health Education 2(4):170-173, 1980.

The Providence Family Medical Center in Seattle, Washington, offers a poison prevention program that provides individual instruction by a member of the health care team to parents of 1- to 5-year-old children who are treated at the center. The instruction covers risk of accidental poisoning in children, hazardous household substances, emergency procedures for accidental ingestion, use of ipecac syrup, and use of the regional poison control center's emergency telephone line. A telephone survey of 46 parents who participated in the program was designed to determine the degree to which parents retained the information presented. Parents in families with a history of high continuity of care (75 percent or more of all health-related calls were to one particular physician) scored significantly better than those with low continuity (less than 75 percent). Parents instructed by their own family physicians scored better than those instructed by others. No association was found between parents' scores and family demographic characteristics, purpose of clinic visit, family history of poisoning, clinician's rating of parent interest and understanding during instruction, or provision of free ipecac syrup. Duration of instruction was inversely correlated with parents' scores. These findings suggest that continuity of care is important in improving parent education. 13 references.

81-1919
"All or None" Evaluation: Is It Valid?
Redican, K. J.
Journal of School Health 50(8):485, October 1980.

One of the major problems affecting health education programs and efforts to evaluate them is that many health educators view health-related decisions and behaviors as absolutes. Viewing a health decision as a choice between a healthy or unhealthy alternative neglects the range of behavior between these extremes. Between the extremes of continued smoking and cessation of smoking are decreased levels of smoking and use of cigarettes with less tar and nicotine. A health education intervention that fails to stop smoking but succeeds in reducing smoking should not be considered a failure.

81-1920
An Assessment of the Incidence of Cigarette Smoking in Fourth Year School Children and the Factors Leading to Its Establishment.
Revill, J. and Drury, C. G.
Public Health (London) 94(4):243-260, July 1980.

A survey was conducted to determine the smoking behavior of 1,014 secondary school students attending 4 schools in Sheffield, England. Two different multiple-choice questionnaires were administered, one to smokers and one to nonsmokers. Results indicated that gender did not influence smoking incidence (24 percent of boys and 28 percent of girls smoked) and that academic ability was negatively related to smoking incidence. Fifty-nine percent of the students began smoking because their friends smoked, and 62 percent reported that they obtained their first cigarette from a friend. A significant association was found between parental smoking and students' smoking habits: the incidence of student smoking almost doubled when at least one parent smoked. Smoking was twice as prevalent among students who drank alcoholic beverages as it was among those who did not drink. Smoking was also found to be a part of a general pattern of social irresponsibility with regard to school attendance, parental control, and conformity to the law. Addiction was the reason suggested for the failure of 78 percent to stop smoking. The survey also suggested that, although boys begin smoking at an earlier age than girls, girls quickly match their male counterparts. While indicating the need for more intensive health education, these findings also suggest that, unless such educational measures are combined with legal and fiscal antismoking measures, the educational interventions will be ineffective. 8 references.

81-1921
Beliefs of Smoking and Nonsmoking College Students About the Effects of Environmental Tobacco Smoke and Related Issues.
Shor, R. E.; Williams, D. C.; Shor, M. B.; Canon, L. K.; and Latta, R. M.
Journal of Drug Education 10(3):263-276, 1980.

In spring 1978, a 147-item questionnaire dealing with the effects of smoking on college campuses was administered to 307 University of New Hampshire undergraduates. The population sample included 62 smoking and 246 nonsmoking students. Data from 1 section, which contained 31 items designed to survey beliefs about environmental tobacco smoke, were of particular interest. Although smokers expressed a statistically significant degree of belief in most of the items indicating that environmental smoke was harmful, their opinions were not strongly held. In general, smokers expressed slightly more skepticism or uncertainty. Both groups expressed quite strong levels of belief on a general statement on health hazards, but considerably less strong levels of belief on statements dealing with specific hazards. These data suggest that people do not have an effective understanding of the meaning and implications of the health hazards of smoking for smokers. 33 references.

81-1922
Children's Health Beliefs and Acceptance of a Dental Preventive Activity.
Weisenberg, M.; Kegeles, S. S.; and Lund, A. K.
Journal of Health and Social Behavior 21(1):59-74, March 1980.

A study involving 254 seventh grade students from 3 urban and suburban schools was undertaken to assess the children's acceptance of a preventive dentistry program based on the Health Belief Model (HBM). An introduction included presentation of a slide show on tooth decay and the effects of fluorides and a demonstration by a dentist of how to apply topical fluoride gel. After the demonstration, students in control schools were given an opportunity to participate in a question-and-answer session; students in one set of intervention schools participated in a shorter question-and-answer period and were given prizes for participation in the program; students in another set of intervention schools participated in the shorter question-and-answer period and in a game designed to emphasize the relevance of the major belief variables of the HBM. All students were asked to participate in a program of topical application of fluoride over a year's period beginning 5.5 months after the presentations. Evaluation questionnaires based on the HBM were administered 2 weeks before the presentations and immediately after the presentations. Data from the questionnaires and program records indicated that the relationship between the students' beliefs about health and their participation in the program did not follow predictions based on the HBM and that perceived efficacy of intervention was the only belief altered by the presentations. Results suggest that health beliefs are often unrelated to behavior. 39 references.

81-1923
A Manual of Evaluation Guidelines for CASPAR--A Model Program in Alcohol Education.
White, R. E. and Biron, R. M.
San Francisco, Calif., Urban and Rural Systems Associates, 1 vol. (various pagings), May 1979.

Guidelines for evaluating the effectiveness of health education programs based on the CASPAR (Cambridge and Somerville Program for Alcoholism Rehabilitation) Alcohol Education Program are provided. The replication projects are operating in Martinsville, Virginia, Statesboro, Georgia, and Plainville, Connecticut. The program relies largely on workshops to train teachers and peer leaders in social means of preventing alcoholism. The evaluation component includes an instrument developed to measure beliefs and attitudes about alcohol use and abuse. The guidelines provide information on scheduling evaluation, gathering information from subjects anonymously, implementing controlled experimental designs if necessary, assessing the immediate effect of the curriculum, assessing the effects of workshops, measuring curriculum implementation, assessing the effects of peer-leader training, sampling target audiences, analyzing data, and reporting results. Copies of all instruments necessary for implementing the evaluation component are appended.

RISK REDUCTION

81-1924
The Smoker--A Family Menace.
Nursing Journal of India (New Delhi) 71(4):91-94, 98, April 1980.

The well-known effects of tobacco use and the global scope of these effects should lead health organizations and professionals to develop effective educational interventions to prevent children from smoking. Statistics indicate that 90 percent of all lung cancer deaths, 25 percent of deaths from cardiovascular disease, and 75 percent of all deaths from chronic bronchitis stem directly from smoking. Smoking can cause heart attacks in women who use oral contraceptives and can damage the fetus. Antismoking programs should aim at reaching all peer and adult influences on children; programs directed toward adults, particularly parents, should emphasize the danger smoking presents to their children as well as to themselves. Survey data indicate that formalized health education has little effect on children's tobacco use, but that role modeling by authority figures can influence children's desire to use tobacco. Physicians should actively attempt to dissuade patients from smoking.

81-1925
Genetic Screening and Counseling: A Multidisciplinary Perspective. Proceedings of a Conference on Genetic Screening and Counseling.
Applewhite, S. R.; Busbee, D. L.; and Borgaonkar, D. S., eds.
Springfield, Ill., Charles C. Thomas, 243 p., 1981.

Papers presented at the Conference on Genetic Screening and Counseling addressed the significance of genetic diseases, clinical counseling for genetic diseases, social-psychological and ethical considerations in genetic counseling, and medicolegal issues in genetics. Specific

issues and subjects included the significance of genetic diseases, genetics and birth defects, counseling for fetal alcohol syndrome, clinical genetics and family counseling, counseling for birth defects of multifactorial or unknown etiology, counseling for amniocentesis, clinical cytogenetics and counseling of individuals with chromosomal disorders, the psychiatrist in the genetics clinic, contributions of long-term psychosocial services to the genetic counseling process, social and psychological issues in genetic counseling, genetic control, counseling skills, medicolegal aspects of genetics and standards of care, legal considerations in prenatal care, informed consent and confidentiality in counseling clients, and the genetic counselor and the legal rights of the handicapped. Numerous references.

81-1926
Genetic Diseases and Patient Counseling in Primary Care Practice.
Capasso, S. R.; Scolere-Marshall, L.; and Kistenmacher, M. L.
Urban Health 9(6):20-23, July-August 1980.

A review of the three major etiological categories of inherited disease provides the physician with a background for assisting patients who are confronting problems associated with congenital defects. The three major etiological categories of inherited disease are chromosomal aberrations, single-gene disorders, and multifactorial inheritance. When taking a family history in search of possible genetic abnormalities, the physician must ask about all diseases and malformations that are present in each family member. Subsequently, the physician should be able to give the family correct risk figures and options or refer them to counseling. When counseling a family that has been affected by the birth of a genetically damaged child, the family physician should begin counseling immediately, allow discussion of painful issues, anticipate the family's grief, repeat important points often, facilitate parent-infant bonding, and provide information on support groups and available resources. 6 references.

81-1927
Venereal Disease Prevention.
Cutler, J. C.
Cutis 27(3):321-323, 326-327, March 1981.

A historical overview of the efforts to treat and prevent venereal disease in America since the late 19th century indicates that preventive measures will generally meet societal resistance as long as effective means of treatment are available. During World War I, when no effective cure for syphilis and gonorrhea was available, irrigation of the urethra with silver nitrate was used as a method of prophylaxis. Careful enforcement of required prophylaxis treatments dramatically reduced the initially alarming rate of infection. The availability of sulfonamides and penicillin during World War II led the public health and medical community to believe that prophylactic programs were no longer needed. As a result, infections and resulting disabilities increased, causing public health professionals to promote the use of condoms, vaginal contraceptives, and different patterns of sexual behavior. During the 1920's, it was hoped that contraceptive devices would help prevent pregnancy and sexually transmitted diseases. However, this hope was thwarted by widespread opposition to birth control. Such a contraceptive-prophylactic approach has yet to be adopted. 4 references.

81-1928
Healthy People: The Surgeon General's Report On Health Promotion and Disease Prevention--Background Papers, 1979.
Institute of Medicine, Washington, D.C.
Washington, D.C., Office of the Assistant Secretary for Health and Surgeon General (DHEW (PHS) Publication No. 79-55071A), 484 p., 1979.
Available from: GPO.

An overview of efforts in health promotion and disease prevention is presented. Topics include injury prevention; present and future prospects for prevention of the principal oral diseases; strategies for prevention of mental disorders; the case for preventive strategies in combating cancer; prevention of cardiovascular disease; the potential impact of risk factor modification on coronary heart disease mortality in middle-aged men; prevention of tobacco, alcohol, and drug abuse; psychological factors in preventive medicine; relations among social support, stress, illness, and use of health services; preventive services for the well population; infant and child health; health needs of adolescents; health prevention efforts to reduce functional dependency among the elderly; personnel issues in disease prevention; health promotion in the work environment; health education; economic evidence on prevention; and means of increasing knowledge about prevention. Numerous references.

81-1929
Smoking and Coronary Heart Disease: Current Status of the Problem in Italy and Experiences of the Rome Project of Coronary Heart Disease Prevention.
Ricci, G. and Angelico, F.
Atherosclerosis Reviews 7:297-314, 1980.

In response to an increase in smoking-related diseases, the Rome (Italy) Project of Coronary Heart Disease Prevention was established to help individuals quit smoking. Tobacco consumption in Italy rose 48 percent during 1965-77, despite a 1962 law prohibiting advertisement of tobacco products and a 1975 law prohibiting smoking in improperly ventilated public places. The Rome Project provides individual therapy to at-risk factory workers, 40 to 59 years old, to reduce certain risk factors associated with coronary heart disease. To evaluate the program, workers in certain factories were designated to receive the intervention, while workers in other factories were monitored but did not receive the intervention. Questionnaire data from nearly 5 years of program interventions indicate that the project has been successful in reducing the number of cigarettes smoked by workers who are at risk. Assessment of thiocyanate and carboxyhemoglobin concentrations in the blood of workers in the intervention group indicated that self-reports of lower smoking rates were truthful. A questionnaire with more detailed items on smoking behavior is being designed. 23 references.

81-1930
A Political Perspective on the Diet-Heart Controversy.
Richmond, F.
Journal of Nutrition Education 12(4):186-187, October-December 1980.

In dissenting from the hypothesis that diet, and particularly cholesterol intake, is related to incidence of coronary heart disease, the Food and Nutrition Board (FNB) rejects a critical element in the argument for a comprehensive national health program of preventive medicine and nutrition education efforts. Due to the lack of national health education and promotion efforts, the United States has lagged behind many modern nations in public health. The medical establishment's resistance to the use of nutritional guidelines and epidemiological data has also resulted in the absence of departments of nutrition and required nutrition courses in most medical schools. Despite the FNB's denial of the relationship between nutrition and disease, the Departments of Agriculture and Health and Human Services have advised Americans to reduce their intake of saturated fats and cholesterol.

81-1931
Lifesaving in California.
Swanbrow, D.
Quest 5(4):61-65, May 1981.

Since it opened in 1979, the Center for Health Enhancement, Education, and Research at the University of California at Los Angeles has provided 24-day courses in lifestyle adjustment for 500 cardiac, hypertensive, diabetic, or obese patients. The residential program provides workshops, lectures, and psychological counseling as part of a comprehensive preventive medicine program. In the first days of the program, patients' physical conditions, diets, lifestyles, and psychological outlooks are analyzed. Patients then undergo a program of lectures, workshops and counseling. Intensive education, active involvement, and peer support are the primary methods used to change behavior. Before they leave the program, participants are asked to commit themselves to the lifestyle changes that they have already begun and to return for progress evaluations at 6-month intervals. These evaluations have indicated that patients find it easiest to comply with exercise regimens, more difficult to comply with diet regimens, and most difficult to comply with stress reduction regimens.

81-1932
Achieving Higher Level Wellness in the Older Population.
Tager, R. M.
Health Values: Achieving High Level Wellness 5(2):73-80, March-April 1981.

Achieving higher level wellness among the elderly will require emphasis on personal choice and responsibility in health matters and alteration of health-related knowledge, attitudes, behaviors, and risk factors. To increase the health knowledge of the elderly, health professionals can initiate one-to-one counseling sessions, offer group and individual educational programs at gathering places and care facilities for the elderly, disseminate publications of voluntary health and medical organizations, and implement media campaigns. Changing the health-related attitudes of the elderly can best be accomplished with experiential activities, rather than informational approaches. The best approach to risk factors is to separate them into lifestyle factors that can be changed and congenital factors that cannot be changed. Behavior can be modified and treatment prescribed accordingly. The most important target risk factors are smoking, uncontrolled hypertension, alcohol or drug abuse, nutritional problems, lack of exercise, and stress. 12 references.

81P-1933
Alcohol Awareness Project.
Shaner, A.
Mount Holyoke College, South Hadley, MA 01075
1977 - Continuing.

The Alcohol Awareness Project (AAP) of Mount Holyoke College was established to (1) increase awareness within the campus community of facts about alcohol and its effects, (2) help students clarify values about alcohol use, (3) create an atmosphere that supports temperance or abstinence, and (4) support abusers of alcohol and people associated with abusers. Services include peer education, workshops and information sessions for faculty and students, rap sessions and support group meetings for people troubled by alcohol use, a resource center, referral services, dissemination of posters and newsletters, and alcohol education classes. The resource center contains books, pamphlets, films, and other educational materials. Peer counselors received ten 2-hour training sessions focusing on basic counseling and group facilitation techniques. In 1980, alummni who worked in the field of alcoholism or who were recovering alcoholics were speakers at a 3-day conference on women and alcohol. Information to evaluate the program is obtained from the student body via questionnaires, and records are kept on all activities and formal contacts with the target audience. The AAP is funded privately by a grant from R. Brinkley Smithers.

81P-1934
Geriatric Alcohol Program (GAP).
Kehn, L.
Visiting Nurse Association of Albany, 35 Colvin Avenue, Albany, NY 12206
Funding Source: New York State Bureau of Alcoholism and Alcohol Abuse, Albany.
1978 - Continuing.

The Geriatric Alcohol Program (GAP) of Albany, New York, is designed to reach older adults through existing social networks. The program receives referrals and conducts psychosocial and physical assessments. After an older alcholic is identified and brought into a treatment program, visiting nurses work to develop a support system and a plan for better use of leisure time. The Visiting Nurse Association of Albany, which administers the program, has also established alcoholism education for its members, other service agencies, elderly residents, and the general public. During its first year, GAP concentrated its activities in a housing project in Albany. During the second year, the project expanded into the rest of the city and four surrounding townships. The staff consists of two full-time nurses, a part-time secretary, and a part-time project director.

81P-1935
Kommunale Praevention (Community Prevention).
Nuessel, E. and Buchholz, L.
University of Heidelberg, Department for Clinical Social Medicine, Bergheimer Strasse 58, 6900 Heidelberg 1, Federal Republic of Germany
Funding Source: Federal Ministry for Research and Technology, Bonn (West Germany); Robert-Bosch-Foundation, Stuttgart (West Germany); Pharma-Industry Boehringer, Mannheim (West Germany).
1973 - 1990.

"Kommunale Praevention" ("Community Prevention"), which was planned in 1973 and 1974, piloted in 1975 and 1978, and initiated on a full scale in 1980, is designed to alter hazardous lifestyles and clinical manifestations of such lifestyles among the people of two communities. Program staff members offer technical assistance to individuals, schools, social clubs and organizations, and employers who want to develop programs for reducing risk factors of chronic diseases. The program is supported by various media. In 1975, all 30- to 59-year-old residents of the target towns were screened for risk factors. In 1978, a pilot study was undertaken to develop measures for preventing and reducing risk behaviors. In the beginning of 1980, a community prevention model, developed during the earlier stages, was implemented. The target communities are Eberback and Weisloch, with populations of 16,000 and 23,000. The community of Neckargemuund, which has a population of 12,000, serves as a control. The program operates under a contract with the World Health Organization and maintains liaisons with similar programs in the Federal Republic of Germany. Over the next 10 years, the classical risk factors of coronary heart disease and blood parameters for liver and kidney lesions in the populations of the three communities will be assessed at 2- to 3-year intervals.

81P-1936
Reach for Health.
Randt, G. and Ward, M.
Riverside Hospital Center for Health Promotion, 1600 N. Superior Street, Toledo, OH 43604
Funding Source: Department of Housing and Urban Development, Washington, D.C. Office of Urban Development Grants; Riverside Hospital, Toledo, Ohio.
October 1980 - Continuing.

"Reach for Health" is designed to (1) increase the awareness of employees, staff, and patients of Riverside Hospital in Toledo, Ohio, and the surrounding community of the magnitude of lifestyle-related illness in the population, and (2) develop a screening program, health education and

behavior change programs, and a data-collection system. Classes are offered on aerobic exercise, individual exercise regimens, weight training, nutrition, smoking cessation, medical self-help, parenting skills, weight reduction, and stress management. Screening is provided on a fee basis. Exercise facilities are available for patients with chronic illnesses or special problems that can be partially resolved by exercise. Program staff also help small businesses and industries in the community meet occupational safety and health standards. The program uses lectures, discussions, group support, seminars, and demonstrations. The target audience includes the hospital employee population (1,200), medical staff, hospital board members, hospital volunteers, local business and industry, and the general public within the hospital's catchment area. Principal program staff include a physician who acts as program director, an administrative director, a health education manager, and an exercise physiologist. The center has coordinated its activities with the American Lung Association, the American Cancer Society, the University of Toledo, and the Guadalupe Family Health Center. Evaluation is conducted through assessment of individual participants, standard assessments of health education course outcomes, and review of hospital employee records and admission records.

81P-1937
Siskiyou Wellness Institute.
Berry, B.; Weil, P.; and Vines, S.
25 Hawthorne, Medford, OR 97501
1979 - Continuing.

The Siskiyou Wellness Institute of Ashland, Oregon, is a private, nonprofit organization of health professionals which was established to help people assume greater responsibility for their health. The program integrates stress management, nutritional awareness, exercise, and environmental awareness. Approaches include self-health inventories and goal setting, stress management and pain control techniques, biofeedback and autogenic skill development, nutrition counseling, exercise programs, medical self-care skills training, nondiet weight control programs, therapeutic touch workshops, and cancer and chronic illness workshops. The institute develops programs for schools, hospitals, and industry. In addition, the institute offers groups for children with life-threatening diseases, operates a residential treatment program, and publishes a quarterly newsletter. The target audience includes adults and children with chronic or life-threatening illnesses, people who want to develop health skills, and people with high-stress lifestyles. The staff includes four registered nurses. Fees from users have covered operating costs so far. Contributions and grants from individuals and organizations will be sought in the future.

SCHOOL HEALTH EDUCATION

81-1938
School Health Practice.
Anderson, C. L. and Creswell, W. H.
7th ed. St. Louis, Mo., Mosby, 512 p., 1980.

Guidelines for developing school health programs are provided. Topics include the historical development of school health and health education programming, health of the normal child, physical growth and development, emotional development, abnormal development, the basic plan of the health program, health services evaluation, preventive health services, remedial health services, health education and health behavior, elementary school health curriculum, junior high or middle school curriculum, senior high school health curriculum, health contributions of high school subjects, the healthful school environment, and school health practice evaluation. Appendices include listings of resources in health, record and report forms, a school health program evaluation scale, and an evaluation checklist for school health programs. Numerous references.

81-1939
Health Through Discovery.
Dintiman, G. B. and Greenberg, J. S.
Reading, Mass., Addison-Wesley, 554 p., 1980.

Textual material for use in a college introductory health course is provided. Topics include the concept of health; body systems; psychosocial aspects of health; cardiovascular health; fitness and health; nutrition; weight control; mental health; stress; drug use and abuse; alcohol; tobacco; communicable diseases; noncommunicable diseases; prevention and treatment of injuries; male and female sexuality; contraception; pregnancy and birth; sexual behavior and response; dating behavior; marriage; parenthood; family life; consumer health; environmental health; medical services and health insurance; health ethics; and aging, dying, and death. A guide to nutritive value is appended. Numerous references.

81-1940
Teaching About Alcohol: Concepts, Methods, and Classroom Activities.
Finn, P. and O'Gorman, P. A.
Boston, Allyn and Bacon, Inc., 241 p., 1981.

Guidelines for implementing alcohol education programs at the elementary, secondary, and postsecondary school levels are provided. Topics include the goals and objec-

tives of alcohol education, primary prevention, background information on alcohol use and nonuse, alcohol and youth, selected teaching methods, alcohol education at the elementary level, objective education about alcohol, the role of parents, communication with parents, teacher-training methods, and curriculum development and evaluation. Thirty-three instructional activities are outlined. A list of resources for alcohol education, a glossary, and an index are appended. Numerous references.

81-1941
The Sunflower Cardiopulmonary Research Project of Children.
Greene, L.
Paper presented at the Annual Convention of the American Alliance for Health, Physical Education, Recreation, and Dance (Detroit, Mich., April 10-15, 1980); 7 p.; April 1980.
Available from: ERIC; Order No. ED-189 040.

The Sunflower Project was a 3-year pilot project designed to promote better cardiopulmonary health and to project a positive lifestyle for elementary school children, their parents, and their teachers. The project was conducted by the American Heart Association, the American Lung Association, the University of Kansas Medical School, the Shawnee Mission Kansas School District, and the University of Kansas Department of Health, Physical Education, and Recreation. The project involved an experimental school with an enrollment of 400 students and a control school with 325 students, a total of 250 experimental-group students and 150 control-group students were assessed. Both populations were provided with 80 minutes per week of physical education, but only the experimental-group students received the instructional program in cardiovascular health, pulmonary health, nutrition, and physical fitness. Experimental-group students were also given 60 minutes of fitness breaks per week to help them understand and enjoy fitness exercises. Fitness assessments were taken at the beginning and end of each school year. As compared with control-group students, experimental-group students had lower cholesterol levels, blood pressures, and resting heart rates and higher levels of physical endurance. A 3-year followup is currently underway to assess students' physical activity, nutritional habits, and knowledge.

81-1942
Functional Administration in Physical and Health Education.
Johnson, M. L.
Boston, Houghton Mifflin, 387 p., 1977.

Guidelines for administering physical fitness and health education programs in primary and secondary schools are provided. Topics include systems management in physical fitness and health education, the functional manager, physical education instruction, school recreation, interschool athletics, school health programs, fiscal management, personnel administration, tournaments, maintenance of legality in operations, and community relations programs. Numerous references.

81-1943
Teaching Health Education to the Mildly Mentally Handicapped Child.
Jones, B. and Springer, M.
Health Values: Achieving High Level Wellness 4(6):262-265, November-December 1980.

In teaching health to the mentally handicapped, special attention should be given to high levels of stimulation, concrete directions, decision-making opportunities, and discrimination of alternatives in the decision-making process. Student learning opportunities should emphasize behavioral and experiential processes. Behavior modification techniques, therefore, are particularly applicable. Some examples of experiential teaching include personal hygiene, nutrition, physical fitness, safety, bodily functions, alcohol abuse, community health, dental health, interpersonal relationships, and smoking. Although the process through which health is taught to these students should be experientially based, the subject areas should be the same as those covered with nonhandicapped students. The main emphasis in dealing with handicapped students is to break the subject matter down to basic simplified segments that are then taught experientially at the level of each student's functioning and ability. 5 references.

81-1944
Making Decisions: Guidelines for the Development of a Drug Education Program.
Kentucky State Dept. of Education, Frankfort. Div. of Program Development.
Frankfort, Ky., the Department, 2 vol., 274 p., 1977.
Available from: ERIC; Order No. ED-174 910.

Concepts and instructional experiences for use in drug education programs for grades K-12 are provided for use by teachers. The guidelines allow teachers to develop additional student activities, audiovisuals, and evaluation tools. Activities incorporated enable students to increase their knowledge about drugs, develop skills in making decisions about drug use, and clarify their values regarding

drug use. A reference section includes pharmacological information on most abused drugs. A primer on alcoholism, listings of treatment programs in Kentucky, and listings of additional State and national sources of information are appended.

81-1945
Towards the Prevention of Mental Retardation in the Next Generation. Volume 1.
Litch, S.
New Haven, Ind., East Allen County Schools, 334 p., 1978.
Available from: East Allen County Schools, 1240 U.S. 30-East, New Haven, IN 46774.

Guidelines for implementing a 15-session educational program designed to prevent mental retardation are provided for use by junior and senior high school teachers. Topics include the responsibility of the teenager, responsibility of the adult, male and female roles in family planning, the pregnant woman and the father, labor and birth, and the newborn. All educational aids and evaluation materials necessary for implementing the program are included.

81-1946
Towards the Prevention of Mental Retardation in the Next Generation. Volume II: The Growing Child.
Litch, S. and Moos, J. L.
New Haven, Ind., East Allen County Schools, 536 p., 1979.
Available from: East Allen County Schools, 1240 U.S. 30-East, New Haven, IN 46774.

Guidelines for implementing a 15-session parenthood and early child care course designed to prevent mental retardation are provided for use by junior and senior high school teachers. Topics include the roles of the mother and father in providing the child a proper diet, the medical role of the parents, the role of parents as house managers, the teaching role of parents, the role of parents as psychologists, and the legal roles of parents. All educational aids and evaluation materials necessary for implementing the program are included.

81-1947
Cardioenergetics: An Essential Part of the Physical Education Instructional Program.
New York State Education Dept., Albany. Bureau of General Education Curriculum Development.
Albany, N.Y., the Bureau, 125 p., 1979.
Available from: ERIC; Order No. ED-186 383.

Guidelines for developing a high school physical fitness and heart disease intervention program are provided. The program uses an interdisciplinary approach that provides students with a working knowledge of the cardiovascular system and factors that affect it; stimulates the development of lifestyles that include balanced nutrition, regular aerobic activity, and appropriate amounts of sleep; and strengthens students' learning in other parts of the school curriculum. Most of the program can be presented using standard physical education facilities, such as a gymnasium, pool, and athletic field, but the interdisciplinary nature of the program requires participation by teachers of English, health, home economics, mathematics, reading, science, and visual arts. Factors affecting cardiovascular health that are addressed include age, sex, health and fitness levels, changes in environment, body temperature, body position, sleep, thought and emotion, stress, food, liquid intake, smoking, ingestion of drugs, and exercise. Appendices include copies of tests and recordkeeping devices.

81-1948
Nutrition Education: Manual for Teachers.
New York State Education Dept., Albany. Bureau of School Health Education and Services.
Albany, N.Y., the Department, 115 p., 1979.
Available from: ERIC; Order No. ED-184 683.

Guidelines for implementing nutrition learning experiences are provided for use in conjunction with nutrition curricula developed by the Bureau of School Health Education and Services of the New York State Education Department. Topics include nutrition education for primary grades, intermediate grades, junior high school, and senior high school, and essential nutrition information for teachers. The nutrition educator should have a working knowledge of the evolution of food, effects of the need for food on society, eating behavior, use of food for bodily maintenance and energy production, effects of food on growth and development, effects of nutrition on health, means of achieving optimal weight, the adequacy of the average teenager's diet, nutrition during phases of the reproductive cycle, food ecology, nutrition problems in the United States, programs to improve nutritional well-being, global nutrition, and nutrition research. Appendices include a list of sources of nutrition education materials, a discussion of common misconceptions about food and nutrition, and a summary of the dietary goals of the United States.

81-1949
Taking Risks: Activities and Materials for Teaching About Alcohol, Other Drugs, and Traffic Safety. Book 1--Elementary Level (Grades 3 and 5).
Resnik, H. S.; Inge, C.; Scornienchi, A.; and Shalit, S.
Sacramento, Calif., California State Department of Education, 68 p., 1979.

Materials and activities for use in implementing instruction on drug and alcohol use and traffic safety are provided for fifth and sixth grade teachers. The materials emphasize risk taking as a normal aspect of everyday living and can be used in a variety of ways with little preparation. The 10-day units cover different kinds of risks, motivating factors behind risk-taking, influences of adult role models, safe versus dangerous risks, peer pressure, decision making, advertising, and the rationale behind safety laws. A workbook of information sheets on the exercises is included for making handouts or transparencies.

81-1950
Education in the 80's: Health Education.
Russell, R. D., ed.
Washington, D.C., National Education Association (Education in the 80's), 126 p., 1981.
Available from: National Education Association Distribution Center, Academic Building, Saw Mill Road, West Haven, CT 06516.

Practical guidelines for school health teachers are provided. Topics include a holistic health model, a holistic approach to stress reduction, stress management education, heart health education, consumer health education, nonscientific healing, sexism and ageism, education for healthy sexuality, alcohol and marijuana education, smoking education, drug education, death education, the internationalization of health education, and values instruction in health education. Numerous references.

81-1951
A Systems Model for Cigarette Smoking Educations.
Swanson, J. C. and Gajda, R. S. M.
Journal of Alcohol and Drug Education 22(2):23-27, Winter 1977.

An ecosystems model for smoking education is described. The model views the organism in the context of the environment and assumes that (1) everything is related to everything else; (2) stimulation of one system within the organism stimulates numerous other systems; (3) the systems must detoxify drugs; and (4) smoking places "costs" upon the organism. Based on these assumptions and data on smoking, it is evident that smoking has numerous ill effects on smokers and on nonsmokers who come into contact with smokers. In addition to the obvious internal effects, smoking has external costs, such as increased probability of fire and auto accidents and the price of cigarettes. The systems approach to smoking education facilitates integration of information, encourages inquiry, provides a holistic view of the effects of smoking, and encourages decision making in terms of cost-benefit analysis. 6 references.

81-1952
Organization and Administration of Sex Education Programs.
Whiteside, P. W. 13 p., 1980.
Available from: ERIC; Order No. ED-191 835.

Proper organization and administration of school sex education programs require an understanding of trends in the philosophy of health education, methods and approaches to sex education, principles for curriculum selection, and curriculum development. Recent trends in the field have included removal of the word "sex" from titles of programs, recognition of the need to provide relevant information so that students will not turn to peers as the major source of sex information, and implementation of student-centered approaches. Development of sex education curricula should involve establishment of support from school authorities, assessment of student interests, delineation of curriculum guidelines, identification of competent teachers at ease with their own sexuality, use of a life-cycle approach, use of current methods and techniques, a focus on interpersonal relationships, involvement of parents and the community, continuous research and evaluation components, and teacher-training components. 15 references.

81-1953
Smoking and Cigarette Smoke. An Innovative, Interdisciplinary, Chemically-Oriented Curriculum.
Zoller, U.
Journal of Chemical Education 56(8):518-519, August 1979.

"Smoking and Cigarette Smoke," a chemistry-oriented curriculum unit for 9th- and 10th-graders, has been developed at the division of chemical studies at Haifa University in Oranim, Israel. The modular unit, which can be used in intra- or extracurricular activity, consists of laboratory work accompanied by readings, discussions, and use of support materials. Materials include a student manual, a teacher's guide, a kit for laboratory experiments, and a list of supporting materials. The unit deals with the composi-

tion and characteristics of cigarette smoke and tar and their effects on the body. A laboratory "smoking machine" enables students to examine the effects of cigarette smoke or to extract tar from cigarettes for further analysis. Other experiments allow students to demonstrate the inefficiency of cigarette filters and the effects of cigarette smoke on blood. Psychological and sociological studies on cigarette smoking are also addressed. 6 references.

SELF-CARE

81-1954
Booklets for Patients. (Editorial)
Journal of the Royal College of General Practitioners (Edinburgh) 30(218):514-515, September 1980.

To help parents handle minor childhood ailments without professional aid, a general practice in Birmingham, England, distributed a booklet to parents. The booklet provided information on antenatal care, breast-feeding, infant development, immunization, fevers, diarrhea, and vomiting, and the use of medical services. In a controlled experiment, parents who received the booklet and those who did not were administered a knowledge test, and results indicated that the former performed significantly better than the latter. 6 references.

81-1955
Self-Care is Not a Solipsistic Trap: A Reply to Critics.
Katz, A. H. and Levin, L. S.
International Journal of Health Services 10(2):329-336, 1980.

In an answer to criticism advanced by Robert Crawford and other writers in the field of self-care and self-help, the multiple and varied origins, motivations, and ideologies associated with self-care are reviewed. The self-care movement embodies a broad, popular social resistance to the ills, inequities, and iatrogenic (illness induced inadvertently by physicians or their treatment) elements inherent in highly technological health care systems. Empirical examination of specific programs and formulations reveals that the movement is not purposefully popularizing ideas of individual responsibility for illness or blaming the victim of the illness. Instead, self-help groups operate to decrease dependency and heighten individual political and social awareness of health hazards. 10 references.

81-1956
Self-Care Program Development: A Challenge for Communities. Paper Presented at the Annual Meeting of the American Public Health Association, Detroit, Michigan, October 20, 1980.
Moore, M. J. and Stark, T. L.
Milwaukee, Wisc., Consumer Health Consultants-HOPE, Inc., 10 p., October 20, 1980.

From January 1978 to July 1980, Consumer Health Consultants (CHC) of Milwaukee conducted the 30-month Self-Care Project in Milwaukee County to research and demonstrate to the community the potential of self-care. The project's 18-member advisory board was composed of representatives from the community, health and social service agencies, government, business, labor, universities, and health professions. The project implemented a survey of 598 health and social service agencies, businesses, and health institutions to identify existing self-care programs; promoted self-care by sponsoring workshops, seminars, and conferences for consumers and providers; and provided technical assistance to agencies, community groups, and businesses interested in implementing or evaluating self-care programs. In addition to ten 12-month technical assistance projects, CHC provided short-term assistance to over 50 organizations. Each of the 10 projects receiving 12 months of assistance has sustained self-care activities. Many have received or allocated funds to continue programming and have introduced new techniques for collecting data and evaluating program effectiveness. Essential to the success of this technical assistance venture were the direct involvement of program staff and the target population in planning, support and reinforcement by CHC, adequate staff time for planning, and flexibility. 6 references.

81-1957
A View of Self-Care as Seen by Patients.
Nebeck, B.
Nephrology Nurse 2(6):27-28, November-December 1980.

The Burtec proprietary outpatient clinic in La Jolla, California, has established a self-care section for dialysis patients. After Burtec staff assessed self-care services offered throughout the county, a memorandum was sent to each clinic patient to explain the program. Subsequently, personal invitations were distributed to patients asking them to meet with Burtec staff to explore their personal concepts of self-care. Each invitation was accompanied by a questionnaire designed to elicit information about interest in self-care. Of the 57 patients provided with questionnaires, 8 showed an interest, and 6 were undecided.

Those patients who showed an interest in self-care varied greatly in terms of the extent of self-care with which they claimed to feel comfortable. Only one patient actually agreed to begin self-care training. Patients were generally negative about self-care due to the lack of financial incentive, the extra time involved, and objections to shift changes. Burtec staff hope that the one patient who agreed to self-care training will serve as a role model for others.

81-1958
Help Yourself to Health: A Health Information and Services Directory.
Ulene, A. and Feldman, S.
New York, Putnam, 1 v. (unpaginated), 1980.

A comprehensive compilation of health information resources is provided to help consumers locate free or low-cost information on medical care. The annotated citations of resources include over 3,000 brochures, 600 free or low-cost health services, and 200 health groups. The names and addresses of all organizations mentioned and an index of all publications, services, and organizations listed are appended.

SEX EDUCATION

81-1959
Parent-Child Sex Education: A Training Module.
Brown, J. G.; Downs, M. M.; Peterson, L.; and Simpson, C. A.
St. Joseph, Mo., Parent-Child Experience, Inc., 80 p., 1980.

Guidelines for implementing a parent-child sex education curriculum are provided. Courses for various age and sex groups, minilectures, and course activities are outlined. Separate course outlines cover curricula for 9- to 12-year-old girls and their mothers, adolescent girls and their mothers, 9- to 12-year-old boys and their fathers, and adolescent boys and their fathers. The minilectures cover the anatomy and physiology of sex and reproduction, contraception, dating, and sexually transmitted diseases. Listings of films, pamphlets, and books are appended.

81-1960
Developing Community Support: A First Step Toward a School Sex Education Program.
Chethik, B. B.
Journal of School Health (Special Issue: Sex Education in the Public Schools) 51(4):266-270, April 1980.

In response to 1977 legislation allowing Michigan school districts to offer birth control instruction, the Washtenaw County health department organized a conference of representatives from each of the county's 10 school districts. The department, which serves a population of 250,000, sent letters to 80 school administrators, and members of its staff visited each school district in the county. The largest paper in the county ran a 10-part series on the conference and school sex education. The 150-member conference included multidisciplinary teams from every school district and 25 facilitators. Conferees included parents, students, school board members, teachers, clergymen, health professionals, physicians, social workers, and lawyers. Planning committees were developed to formulate a bibliography of sex education materials, develop the conference program, recruit speakers, develop a preconference information packet, promote the conference, and appoint group discussion leaders. The conference consisted of one large group session, six workshops, and a media fair. It resulted in enrollment of 120 teachers and nurses from 9 school districts in a department-sponsored teacher education program on sexuality, creation by 8 districts of advisory committees for sex education, and plans to create such a committee by a ninth district. The county's experience shows that community agencies such as health departments can facilitate the development of educational programs by involving community members who favor sex education, contacting key administrators, and holding a planning conference.

81-1961
Mandated Family Life Education: A Rose Is a Rose Is a Rose Is a Rose.
Darden, J. S., Jr.
Journal of School Health (Special Issue: Sex Education in the Public Schools) 51(4):292-294, April 1981.

After the adoption of a policy statement on sex education by the New Jersey State Board of Education in 1967, school districts in the State were encouraged to adopt sex education programs, and the State Department of Education published guidelines for program development. Though public school programs were blocked by a public backlash that resulted in a statewide moratorium on sex education programs from July 1969 to July 1970, universities throughout the State continued to offer sex education courses. Alarm over the social disruptions of the "sexual revolution" of the late 1960's resulted in the January 1979 appointment (by the president of the State Board of Education) of a five-member committee to examine and recommend improvements in State policy on teaching sex

education in public schools. The committee found that only 40 percent of the State's pupils were receiving instruction in family life and sex education. In April 1980, the State board voted to require comprehensive sex education in all public schools. Though public reaction has delayed implementation until 1983, the mandate was strengthened by the formation of a curriculum committee by the State Department of Education. Local interpretation of the guidelines is being encouraged, but the need to provide family life and sex education is emphasized. As a result, New Jersey has become one of three States with legally mandated sex education. 5 references.

81-1962
Reaching Teenagers With Sex Information.
Feldman, M.
Paper presented at the Annual Meeting of the National Council on Family Relations (Boston, Mass., August 14-18, 1979), 12 p., August 1979.
Available from: ERIC, Order No. ED-184 027.

A review of health records and the pertinent literature and the results of research indicated that the problem of teenage pregnancy can be viewed as an endemic part of American culture. Although the number of girls under 15 years old who are becoming pregnant is not very large (13,000 in 1978), the cost of pregnancy--for the girls, their families, and society--is great. Data gathered and analyzed during the review indicate that (1) illegitimate-birth rates do not follow seasonal variations; (2) the major source of sex information is the peer group; and (3) there is widespread misinformation among teenagers about contraceptives and the "safe time" to participate in intercourse. Intervention projects to deal with adolescent pregnancy can be conducted by schools, churches, and parent-teacher association groups. 6 references.

81-1963
Teacher Training for Sex Education.
Flaherty, C. and Smith, P. B.
Journal of School Health (Special Issue: Sex Education in the Public Schools) 51(4):261-264, April 1981.

A 3-year training program for teachers of sex education was conducted by the Population Program of the Baylor College of Medicine in Houston, Texas, in cooperation with the Houston Independent School District. Using a grant from the March of Dimes Birth Defects Foundation, the program reviewed existing curricula and teacher-training programs, established working relationships with school district personnel and community representatives, formed a committee of health professionals and school district personnel, and developed a training manual. A 72-hour training program for teacher trainers was conducted from mid-January through mid-March 1980. During the third year of the program, staff and advisory committees selected student curricula, taught 150 students using the curricula, evaluated the effectiveness of the teacher training based on classroom performance, and revised the training manual. Teachers were selected for training using a strict set of criteria, and a multidisciplinary approach to sex education was emphasized. The success of the program was attributed to involvement of school district personnel and community representatives during planning and implementation, support from key administrators and school board members, use of a strong theoretical framework, establishment of advisory committees of professionals and laypeople, use of indigenous personnel as teacher trainers and decision makers, careful documentation, and clear distinction between approaches and materials used to train students and those used with adults. 15 references.

81-1964
Family Life and Sex Education: Selected Audio-Visual Aids.
International Planned Parenthood Federation, London (England). Audio-Visual Resource Unit.
London, England, the Federation, 60 p., July 1978.
Available from: Library and Documentation Service, International Planned Parenthood Federation, 18-20 Lower Regent St., London, SW1Y 4PW, England.

An annotated selection of audiovisual aids on family life and sex education courses is provided. The citations include films, multimedia kits, slides, overhead transparencies, tapes, flannelgraphs, charts, flip-books, flashcards, models, and games. All items listed may be viewed by appointment at the education department's audiovisual resource unit at the International Planned Parenthood Federation's central office in London, England. A subject index is appended.

81-1965
Curbing the Rising Tide of Teenage Pregnancies in the U.S.: Primary Preventive Approaches for Communities, Schools, and Parents.
Jackson, V. D. and Kidwell, J. S.
Health Values: Achieving High Level Wellness 4(6):269-273, November-December 1980.

Factors contributing to the rise in adolescent pregnancy are examined and practical preventive approaches to the problem for schools, communities, and parents are sug-

gested. The ambivalence surrounding sexual topics (the media promotes sexual activity while society condemns sex before marriage) and the controversial nature of sex education have prevented teenagers from receiving necessary sex and family life education. Adolescents need to understand their sexuality, because confidence about sexuality can lead to a view of sex as a deliberate behavior involving responsibility and informed choices. Success in controlling adolescent pregnancy depends on cooperation among community, parents, and school. Primary prevention guidelines for community planners, teachers, administrators, and parents are appended. 13 references.

81-1966

Out of the Locker Room and Into the Classroom: Innovative Approaches to the Use of Media and Strategies in Sex Education for the Deaf.

Kessler, M. I.

American Annals of the Deaf 125(6):822-825, September 1980.

As part of the development of a college-level human sexuality course at the National Technical Institute for the Deaf (NTID) at the Rochester Institute of Technology, a film on contraception was edited to include studio segments in which students and staff underscore important points. A media search conducted through the department of media services at NTID in 1978 found no visual materials produced specifically for the deaf on human sexuality. Rather than use one of the few silent films available or simply caption a film, NTID modified a film for hearing audiences by adding synchronized captions, developing a cross-referenced vocabulary list for distribution to the audience, and replacing segments of the film that contained physicians' discussion with studio segments that were more accurate. Using five deaf students and two hearing faculty members, discussion segments were videotaped in a studio. The communication mode was manual-simultaneous communication. Students were given reading materials 1 week before seeing the film, and the presentation was reinforced by overhead transparencies. Class discussion and an evaluation segment on the final exam indicated that the film increased students' understanding of contraceptive methods. 4 references.

81-1967

They'll Read If It Matters: Study Guides for Books About Pregnancy and Parenting.

Lindsay, J.

Buena Park, Calif., Morning Glory Press, 242 p., 1977.

Study guides for books about pregnancy and parenting are provided for use by teachers of special education classes for pregnant minors. The guides cover books on prenatal care, facts about sex for adolescents, life before birth, the birth process, sex and birth control, the first 6 weeks of life, the baby and the family, child care, infant care, infant education, infant nutrition, and single parenthood. Appendices include a discussion of how to obtain the books, an annotated list of the 60 best resource materials, and a list of free or inexpensive materials.

81-1968

You'll Read If It Matters: Student Manual of Study Guides for Books About Pregnancy and Parenting.

Lindsay, J.

Buena Park, Calif. Morning Glory Press, 142 p., 1977.

An overview of 15 of the most popular books on pregnancy and infant care is provided for use by students. The books address prenatal care, facts about sex, contraception and pregnancy, fetal development, the birth process, family planning, sex and birth control, the first 6 weeks of life, the baby and the family, toilet training, nutrition, infant growth and development, accident prevention, immunizations and allergies, respiratory problems, problem infants, the infant's eyes, medication and treatment of the infant, and the single-parent experience.

81-1969

Sex Education Guidelines, Including Reproductive Health and Family Planning.

Michigan State Dept. of Education, Lansing.

Lansing, Mich., the Department, 24 p., 1978.

Available from: ERIC; Order No. ED-186 354.

In Michigan, legislation requires that the State Board of Education establish approval criteria for those who will be supervising instructional programs in sex education; determine certification requirements for those teaching classes in sex education; and establish guidelines for reviewing and recommending materials for teaching about family planning, reproduction, and venereal diseases. Certified teachers must have preparation in the biological and behavioral sciences, sex education, and health education. Areas that must be covered, according to law, are reproductive health, family planning, sexuality, family life, venereal disease, fetology, marriage, and genetics. Appendices include the laws relating to health education in Michigan public schools and the notice sent to parents about the incorporation of sex education courses into the curriculum.

81-1970
Pre and Post Test Evaluation of Students' Values Taking Human Sexuality Classes at University of Utah: "Does Sex Education Change Students' Values?"
Reagan, P. A.
Salt Lake City, Utah, College of Health, University of Utah, 12 p., 1980.
Available from: ERIC; Order No. ED-189 039.

A study involving 36 female and 20 male undergraduates attending the University of Utah assessed the students' values before and after a 30-hour nonmoralistic sex education course. The course placed no emphasis on religious values, promoted open discussion, and introduced information on birth, family planning, sexual orientation, abortion, masturbation, and sexual intimacy. The course had a lecture-discussion format and used one textbook, two films, sample contraceptive devices, and overhead transparencies. Guest speakers included a panel of gay men and women. A questionnaire administered before and after the course measured perceived values of the instructor, values of the students, and self-reported values of the instructor. Questionnaire data indicated that (1) students showed no change in sexual philosophy (conservative, moderate, liberal, or radical) as a result of the course; (2) students' acceptance of homosexuality, masturbation, and abortion increased significantly due to the course; and (3) there was a significant increase in critical attitudes of students toward premarital sex. 8 references.

81-1971
Attitude of Teachers Towards Introduction of Sex Education in Schools.
Reddy, A. V. R. and Babaiah, S. G.
Journal of Family Welfare 26(1):15-22, September 1979.

An attitudinal survey of 240 teachers working as bachelor of education assistants in secondary schools in the Nellore and Chittoor districts of Andhra Pradesh, India, was designed to assess the reactions of different categories of teachers toward introduction of sex education. The sample population was equally divided between the sexes. The Likert-style attitude survey contained 36 items that were selected after a review of the literature, a review by 55 teachers, and pilot testing. Analysis of the results indicated that (1) the teachers in general had a favorable attitude toward introduction of sex education at the secondary school level; (2) male teachers were significantly more likely to favor sex education; and (3) married teachers were slightly, but not significantly, more likely to favor introduction of sex education. 16 references.

81-1972
The Nurse's Role in Primary Prevention in Sexual Health.
Roesel, R.
Imprint 27(5):27-28, December 1980.

Nurses should be able to provide guidance in relationship to sexual health. A permissive attitude on the part of the nurse helps clients explore their concerns regarding sexual health, encourages them to reconsider behaviors and feelings formerly seen as abnormal, and opens channels for discussion of future concerns. Parents should understand that their means of handling, toilet training, clothing, and playing with their children and their means of dealing with their children's masturbatory tendencies affect the sexuality of the children. Parents should also understand periods of homosexuality during many children's school years, emotional and physical changes that accompany puberty, influences of peers, and the tendency in recent years toward more sexual experimentation during adolescence. Finally, the nurse must be ready to dispel myths concerning the asexual nature of the elderly. 8 references.

81-1973
Adolescent Pregnancy Prevention--School-Community Cooperation.
Shapiro, C. H.
Springfield, Ill., Charles C. Thomas, 129 p., 1981.

An overview of adolescent sexual activity and guidelines for school and community responses to prevent adolescent pregnancy are provided for use by parents, teachers, religious leaders, and family planners. Topics include sexual learning and self-esteem, the male as an afterthought in sex education, the disabled adolescent, peer support networks, parents as sex educators of their children, the potential role of religious institutions in sex education, change through school-community cooperation, birth control, and sexually transmitted diseases. An annotated list of audiovisual aids for use in sex education programs is appended.

81-1974
Sexual Learning: The Short-Changed Adolescent Male.
Shapiro, C. H.
Social Work 25(6):489-493, November 1980.

Recent sex education efforts have tended to emphasize the adolescent female and have paid little attention to the adolescent male. A survey of 1,400 parents in Cleveland, Ohio, revealed that less than 2 percent of the fathers and only 9 percent of the mothers had discussed premarital

sex with their sons. A survey of 1,000 New York City adolescents suggested that males, as compared with females, thought parents were more accepting of their sexual behavior. The Cleveland study supports this finding by reporting that parents were far more accepting of premarital sex among adolescent boys than among adolescent girls. Sex education for male and female adolescents should involve integrated efforts by parents, schools, community agencies, and religious institutions. Unfortunately, such efforts have been hampered by sexist attitudes such as those revealed by the New York and Cleveland studies. To remedy this problem, it will be necessary to form parent education groups to dispel myths about adolescent sexuality, provide factual information about sex, and help build communication skills. In addition, schools must expand their programs to respond to the needs of boys by dealing with moral and ethical issues, increasing outreach efforts aimed at young males, and providing counseling. Finally, community agencies and religious institutions should direct significant attention to the sexual problems of young males, and male peer support groups should be initiated. Numerous references.

81-1975
Teaching Sex Education to Multiply Handicapped Adolescents.
Smigielski, P. A. and Steinmann, M. J.
Journal of School Health (Special Issue: Sex Education in the Public Schools) 51(4):238-241, April 1981.

As the trend toward educating the mentally handicapped outside of institutions grows, nurses and health educators must prepare themselves to provide sex education for children who are both mentally handicapped and visually impaired. Methods for teaching the mentally retarded include task analysis, use of concrete materials, repetition of information, and practice of functional skills. Use of audiovisual materials can overcome the retarded child's inability to comprehend printed material or verbal presentations. Several curricula, which use these teaching methods as well as audiovisuals, have been developed for distribution. Children with visual impairments can be taught via input from the other senses. The lack of mobility and the stigma of blindness, which impede peer interaction, must be overcome in any sex education program for this population. A teaching plan for blind adolescents should incorporate concrete education, use of the other senses, reinforcement from peers and significant others, and opportunities for social learning. Talking books, large-print books, and books in braille are available on a variety of sexual topics, and various companies have produced audiotape sex education programs. A case study of a 19-year-old retarded blind man indicates the value of carefully assessing the student and implementing sex education programs formulated according to individual needs. 14 references.

81-1976
Sex Education Can Help Stop Drug Abuse.
Training for Living, Inc., Mattituck. N.Y.
Mattituck, N.Y., TFL Press, 10 p., 1977.

Evidence gathered at the Training for Living Institute (a Mattituck, New York, nonprofit organization that trains human services specialists) during 5 years of work with urban adolescent drug abusers suggests a strong link between drug and alcohol abuse and sexual anxiety. Parents and teachers should nurture the self-image of adolescents, who often turn to drugs to escape inner doubts and fears. To help parents deal with children about sexual matters, (1) parent-child communication should be established early and maintained; (2) parents should try to understand the conflicts of puberty; and (3) parents should provide sex information that considers emotional drives as well as physiological functions. Two case studies are presented that demonstrate how sexual anxieties can trigger drug abuse.

81P-1977
Male Teen Program.
Williams, M.
Planned Parenthood of Atlanta, 15 Peachtree Street, N.E., Suite 909, Atlanta, GA 30303
Funding Source: Georgia State Dept. of Human Resources, Atlanta.
1979 - Continuing.

The Male Teen Program of Fulton County, Georgia, educates young males in human reproduction and family planning. Program services include community outreach to contact target audiences and community leaders, inservice education for personnel who come into contact with teens, educational sessions for community leaders and young males, educational and rap sessions with informal groups, and distribution of contraceptives. A media campaign, aimed at male teens, used posters, radio and television spots, newspaper articles, a trigger film (a short film used to prompt discussion), and pamphlets. Due to funding delays, the program reduced its target area to a single health service area, the Neighborhood Union. This district is predominantly black, and the income of 34 percent of its population is below the poverty line. The area has one of the highest rates of births to 15- to 19-year-old women in Fulton County. The program focused on young men, 16 to 19 years old, because preliminary data from a Grady

Hospital study showed that approximately 66 percent of the fathers of children born to young mothers were in that age group. In planning and implementing the program, Planned Parenthood of Atlanta, the administering agency, received help from the Fulton County Health Department, the Atlanta Southside Community Health Center, the Teen Services Program of Grady Hospital, Spelman College Family Planning, and Emory-Grady Family Planning. These organizations formed the Fulton County Family Planning Coalition. Data from pre- and postprogram questionnaires have indicated that (1) a continuing effort to present factual information about sexuality to young men is necessary; (2) venereal disease is a good topic for creating interest; (3) outreach workers should have a working familiarity with the culture of the target audience; and (4) the target audience should be expanded to include 13- to 15-year-olds. A manual has been produced to facilitate replication of the program in other settings.

81P-1978
Men's Reproductive Health Clinic.
Ong, T.
San Francisco Department of Public Health, Family Planning Program, Health Center No. 4, 1490 Mason Street, San Francisco, CA 94133
Funding Source: Bureau of Community Health Services (DHHS, HSA), Rockville, Md.
1976 - Continuing.

The Men's Reproductive Health Clinic in San Francisco, California, is a free general health clinic for men that emphasizes sexuality and birth control information and counseling. The clinic provides contraceptives; tests for sexually transmitted diseases; physical checkups; a course for men and women on natural family planning; information, counseling, and referrals for vasectomy procedures; sex counseling and referral for sexual dysfunctions, general health education; and outreach education to San Francisco public schools and area agencies. Bilingual services are available to Chinese and Hispanics. The clinic operates 2 days a week for a total weekly operating time of 3 hours and 15 minutes. The clinic is staffed by a public health physician, a pediatrician, a coordinator with an academic background in health and medical sciences, a coordinator of outreach and education who is also a counselor and medical aide, a bilingual educator, counselors, and a peer educator. Statistical information is kept on users of the clinic's services.

81P-1979
Planned Parenthood of Dane County-SPRITE Male Sex Education Program.
Gray-Johnson, R.
Planned Parenthood of Dane County, 1050 Regent Street, Madison, WI 53715
1979 - Continuing.

The Male Sex Education Program is part of SPRITE (Support, Pride, Readiness, Involvement, Teamwork, and Education), a prerelease, outward-bound program for incarcerated youth at Ethan Allen School and Lincoln Heights School in Dane County, Wisconsin. The overall prerelease program is administered by the Wisconsin Correctional Camp System of the Division of Corrections. In SPRITE, selected groups participate in a 28-day undertaking in wilderness and urban settings to improve their self-confidence, self-control, and decision-making abilities. As part of the urban experience, the group participates in a 150-minute sexuality education and counseling session with a female community educator and a male volunteer or SPRITE counselor. The sessions encourage participants to share their feelings about sexuality. Through discussions on birth control, anatomy, physiology, and relationships, the discussion leaders try to be supportive and communicate the value of planned parenthood agencies as a source of continuous services.

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MMOB	
OPNR	
UPNS	
Discount	
Refund	

*Prices subject to change.

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