Prevention bulletin
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Kids begin learning about sun safety in school

By Will Humble

In Arizona, where sunshine is plentiful and risk is considerably greater in developing skin cancer than other parts of the country, it is critical that children be protected from sun exposure and that they develop a life-long habit of prevention.

Increasing the percentage of Arizona children that regularly use effective sun protection is one of Arizona's Healthy 2010 objectives. The Department began implementing the Environmental Protection Agency's SunWise elementary school program in January 2003.

The program encourages elementary schools to adopt sun-safe policies and promote sun safety educational programs in order to encourage safe life-long exposure behaviors. Schools that participate in the SunWise program receive curriculum materials including lesson plans developed by teachers to educate students about the importance of safe sun exposure habits. The program also encourages schools to promote sun protection at school, including encouraging students to use sunscreen and hats.

The Arizona SunWise program kicked off its activities with a very successful poster contest in partnership with the Arizona Diamondbacks and Curt and Shonda Schilling's SHADE Foundation. Several thousand students from all over the State drew creative posters that demonstrate ways that they can protect themselves from excessive UV ray exposure. The winning posters will be professionally reproduced, and distributed at no charge this summer to Arizona pediatricians, dermatologists, and classrooms to help raise awareness of the simple ways that kids can protect themselves.

Publicity from the contest and from staff visits to numerous schools has resulted in an incredible interest on the part of school administrators, teachers and parents in the Arizona SunWise School program. In the first three months of the program, more than 250 schools have registered to become Arizona SunWise Schools. The program successes in Arizona prompted the USEPA Administrator, Christie Todd Whitman to visit Arizona on March 26, 2003 to promote the Arizona SunWise program.

For more information log onto *www.hs.state.az.us/phs/oeh/invsurv/sunwise/index.htm* or contact the Arizona Department of Health Services SunWise coordinator, Sharon McKenna at 1.800.367.6412 or smckenn@hs.state.az.us for information about becoming a SunWise school.

Will Humble is the Office Chief of Environmental Health and can be reached at 602.230.5941 or whumble@hs.state.az.us.

Arizona Department of Health Services

Visit the ADHS Web site at www.hs.state.az.us

To Mask or Not To Mask - Or Is That The Question?

By Dr. Bob England, State Epidemiologist

Severe Acute Respiratory Syndrome (SARS) has been demonstrating how small the world we inhabit really is. Progression of the epidemic and our response to it have been evolving rapidly, and there is little to write here that could possibly be up-to-date by the time you read this. We urge you to frequently check the CDC website, *www.cdc.gov* for updated information and guidelines. There's a wealth of material there, much of it changing daily. A few take home points in the meantime.

1. This disease is truly new, but there's nothing odd about that. Emerging diseases have appeared throughout history and will continue to do so. Whether this coronavirus actually originated by jumping host species will perhaps be determined in the future.
2. The virus appears moderately infectious (behaving as if communicable via contact with secretions or by droplet spread). In some cases the route of transmission remains obscure, but this is not wildly infectious like measles or chicken pox or influenza. Think of it this way… the outbreak began, as far as we can tell, last November in China. That's about the same time as the flu season gets rolling; yet, by this time each year, influenza has infected millions all around the globe. The spread of SARS is clearly frightening, but if it were as infectious as the flu or even as infectious as many other coronaviruses, our goose would be cooked. Once again, dumb luck triumphs and reasonable droplet precautions provide fairly good control of transmission.
3. Having said that, transmission can occur explosively within a health care setting if precautions aren't implemented promptly. Therefore, we urge clinic settings

where people might first present, especially emergency departments and urgent care centers, to ask patients with respiratory complaints or fever whether they have recently traveled to those places where community spread has occurred (see inset). If there is such a history, please implement precautions immediately. Put a surgical mask on such patients during triage or evaluation until you can implement standard contact and airborne precautions (see *www.cdc.gov* for full discussion).

4. There is no specific treatment yet, although early supportive care does seem to make a considerable difference. Multiple treatments are already under investigation. Before initiating treatment please check the latest update on the CDC website and involve the appropriate consultants.
5. Because we didn't have immediately available tests that are sensitive and specific for this infection, we've been using a syndromic case definition. The U.S. version of the "suspect case" definition is much broader than the World Health Organization (WHO) "probable case" version. (See inset for case definition). Thus, many of those currently on the suspect case list in the U.S. will turn out to have never had SARS once all is said and done. As it is, the current suspect case list fluctuates as new suspects are added while others are ruled out.

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SARS: Case Definition

Suspected Case

Respiratory illness of unknown etiology with onset since February 1, 2003, and the following criteria:

- Measured temperature greater than 100.4°F (greater than 38°C) **AND**
- One or more clinical findings of respiratory illness (e.g. cough, shortness of breath, difficulty breathing, hypoxia, or radiographic findings of either pneumonia or acute respiratory distress syndrome) **AND**
- Travel† within 10 days of onset of symptoms to an area with documented or suspected community transmission of SARS (see list below; excludes areas with secondary cases limited to healthcare workers or direct household contacts) **OR**
- Close contact* within 10 days of onset of symptoms with a person known to be a suspect SARS case.

Probable Case

A suspect case with one of the following:

- Radiographic evidence of pneumonia or respiratory distress syndrome
- Autopsy findings consistent with respiratory distress syndrome without an identifiable cause

Areas with documented or suspected community transmission of SARS: Peoples' Republic of China (i.e., mainland China and Hong Kong Special Administrative Region); Hanoi, Vietnam; Singapore; and Toronto, Canada.

For the latest information on SARS, including updated case definition, go to *www.cdc.gov*.

†Travel includes transit in an airport in an area with documented or suspected community transmission of SARS.

*Close contact is defined as having cared for, having lived with, or having direct contact with respiratory secretions and/or body fluids of a patient known to be suspect SARS case.

Arizona Experiences Relatively Mild Influenza Season

By Victorio Vaz, D.V.M., Ph.D

We've been lucky again. Influenza activity is tapering off around the country, ending another relatively mild influenza season. Influenza B, which generally causes less severe illness than A, accounted for half of the typed virus, and there was a good antigenic match between the vaccine strains and the circulating H1, H3 and B viruses. The strains for inclusion into next year's vaccine have already been chosen, based on antigenic analysis of globally circulating virus and epidemiologic data.

In February 2003, two human cases of influenza A (H5N1), including one death, were confirmed in Hong Kong. This raised concerns that a larger outbreak would develop, perhaps spreading outwards from people with close exposures to birds. However, no additional cases were detected through enhanced surveillance efforts. The two cases this season were the first observed in humans since 1997 when Hong Kong experienced an outbreak of influenza A (H5N1) in Hong Kong. Until then, this subtype had only been detected in birds. After transmission to humans that year, a large-scale culling of the island's chickens was implemented in order to control the outbreak.

Although neither occurrence of H5N1 influenza led to widespread human morbidity, it is through the recombination of human and avian influenza viruses that serious new strains are likely to arise. Recombination of existing viruses, or antigenic shift, can produce influenza strains to which humans have little immunity, either through past exposure or immunization. A new strain that is particularly virulent or easily transmitted by person-to-person contact could lead to an influenza pandemic. In today's interconnected world, infections can easily spread across the globe in a short period of time. Fortunately, with good global surveillance we should have some warning before reaching the pandemic stage.

In the meantime, it is important for those people at highest risk of complications of influenza to continue to receive the available influenza vaccinations on an annual basis. While this may not offer protection against novel viruses, the vaccine can nonetheless prevent much of the illness we see each year caused by the more familiar influenza subtypes. There is little we do in health care that can as easily prevent as much morbidity and mortality as the annual flu shot for those who most need it.

Victorio Vaz is the Office Chief of the Infectious Disease Section at the Bureau of Epidemiology and Disease Control. He can be reached at 602.230.5932 or vvaz@hs.state.az.us.

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6. A final note of encouragement. The speed of the scientific and public health response to this has been astonishing (*see related story on page 6)*. Due to reporting issues in China that will long remain controversial, the world got a slow start. WHO issued its global alert on March 12th. Although there have been regional differences, guidelines issued almost immediately have demonstrably limited transmission in health care and other settings. Within a few weeks the virus was isolated and various tests were well under development. As this is being written, barely a month into the response, Koch's postulates have been fulfilled in an animal model. The entire genome has been sequenced. Both antibody and PCR tests, already being used in the investigation, may soon be available to clinicians. A variety of public health studies are well under way that will describe spectrum of disease, portals of exit, duration of infectiousness, whether asymptomatic carrier status exists, and so forth.

   That we could be saying this a mere month after recognizing the existence of a new disease is nothing short of a triumph. As unfortunate as SARS has been, this demonstrates the world's ability to cooperatively deal with a novel emerging disease. This bodes very well for our species' ability to cope with yet unimagined but inevitable pandemics, as we continue to coinhabit this planet with the microbes.

Dr. Bob England is the State Epidemiologist and can be reached at 602.230.5823 or benglan@hs.state.az.us.

Communicable Disease Summary
January 1, 2002 - December 31, 2002 – Provisional Data

Confirmed Cases Reported in 2002 by County of Residence — Yearly Totals

DISEASE	Apache	Cochise	Coconino	Gila	Graham	Greenlee	LaPaz	Maricopa	Mohave	Navajo	Pima	Pinal	Santa Cruz	Yavapai	Yuma	Unknown	2002	2001	2000
AIDS	-	-	3	-	-	-	3	441	5	4	52	22	-	7	-	3	540	522	443
Amebiasis	-	-	-	1	-	-	-	17	-	-	2	1	1	2	3	1	28	29	38
Botulism	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	1	0
Botulism, Infant	-	-	-	-	-	-	-	2	1	-	-	-	-	-	-	-	3	2	1
Brucellosis	-	-	-	-	-	-	-	5	-	-	-	-	1	-	-	-	6	6	1
Campylobacteriosis	40	9	61	3	7	-	1	367	11	15	154	15	16	29	2	4	734	635	619
Cholera	-	-	-	-	-	-	-	-	-	-	1	-	-	-	1	-	2	0	0
Chlamydia	369	151	374	104	80	8	37	9684	136	412	2554	341	63	188	429	-	14930	14357	12610
Coccidioidomycosis	2	11	8	17	5	-	7	2337	28	5	575	110	5	9	11	3	3133	2302	1917
Colorado Tick Fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	0
Cryptosporidiosis	-	-	-	-	-	-	-	15	-	1	3	-	-	-	-	-	19	11	10
Dengue	-	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-	2	1	3
E.coli O157:H7	-	1	2	-	1	-	-	25	-	-	6	4	-	-	-	-	39	30	56
Ehrlichiosis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	1	1
Encephalitis, SLE	-	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-	2	1	0
Encephalitis, other	-	-	1	-	-	-	-	10	-	-	1	1	-	1	-	-	14	16	3
Giardiasis	1	3	5	12	6	-	2	161	15	5	38	5	1	8	2	4	268	267	313
Gonorrhea	32	18	31	10	-	-	-	2986	22	97	454	72	11	13	38	-	3784	3923	4136
Haemophilus influenzae	9	-	2		1	-	-	56	11	7	9	3	-	3	-	-	101	81	53
Hansen Disease	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	1	0
Hanta Pulmonary Syndrome	-	-	-	-	-	-	-	3	-	-	-	-	-	-	-	-	3	1	4
Hepatitis A	1	11	4		1	-	1	182	5	8	55	8	13	2	12	3	306	409	467
Hepatitis B	-	4	8	4	4	-	-	147	11	3	45	13	1	3	8	1	252	164	215
Hepatitis B (non-acute)[1]	4	14	16	4	3	-	-	769	22	13	175	46	4	14	32	7	1123	1498	887
Hepatitis C	-	-	-	-	-	-	-	5	-	-	-	-	-	-	-	-	5	9	21
Hepatitis C (non-Acute)[2]	57	168	195	103	111	15	59	6005	606	214	1319	711	25	339	336	17	10280	6818	6092
Hepatitis D	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	5	19
Hepatitis E	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	0
Hepatitis Non-A-B	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	1
Herpes–genital	16	8	20	3	9	-	-	779	25	14	218	29	-	12	19	-	1152	975	1132
HIV infection	4	-	-	-	-	-	3	371	7	-	58	28	-	5	8	-	484	531	403
Legionellosis	-	1	1	1	-	-	1	8	-	-	2	-	-	1	-	-	15	21	11
Leptospirosis	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1	0	0
Listeriosis	-	-	-	-	-	-	-	10	1		4	1	2	-	-	-	18	10	20
Lyme Disease	-	-	-	-	-	-	-	3	-	-	1	-	-	-	-	-	4	3	2
Malaria	-	-	-	-	-	-	-	15	-	-	2	-	-	-	-	-	17	19	11
Measles	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	1	0
Meningitis-Aseptic	2	1	2	-	-	-	-	232	3	2	21	7	-	6	-	-	276	206	163
Meningococcal	-	-	-	-	-	-	-	21	-	2	3	4	1	-	1	-	32	20	33

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Mumps	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	1	1	6
Pertussis	2	-	1	-	-	-	-	58	17	-	18	-	-	183	-	1	280	381	108
Plague	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	1
Q Fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	0
Relapsing Fever, Tick	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	3	0
Reye Syndrome	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	1	0
Rocky Mountain Spotted Fever	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	1	0	0
Rubella	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	1
Congenital Rubella Syndrome	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	0
Salmonellosis	30	24	42	7	8	1	3	395	10	15	171	44	22	16	18	3	809	733	784
Salmonella paratyphi A	-	-	1	-	-	-	-	2	-	-	-	-	-	-	-	-	3	2	4
Salmonella paratyphi B	-	-	-	-	1	-	-	3	-	4	3	-	-	-	-	-	11	3	7
Shigellosis	9	12	22	1	1	-	-	354	1	9	190	28	29	1	10	1	668	483	574
Streptococcal Group A	4	4	21	-	3	-	-	191	3	5	63	16	-	3	-	1	314	187	235
Streptococcal Group B[3]	-	2	-	-	1	-	-	20	-	-	2	2	-	-	-	-	27	55	42
Streptococcus pneumoniae	29	15	29	3	4	1	0	495	25	16	122	41	4	3	1	2	790	782	811
Syphilis	-	-	5	-	-	-	-	155	-	9	29	-	-	-	-	-	198	180	189
Syphilis-Congenital	-	-	-	-	-	-	-	19	-	-	-	-	-	-	-	-	19	32	26
Tetanus	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	1	0
Toxic Shock Syndrome	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	0
Tuberculosis	10	-	9	-	-	-	-	172	4	9	24	14	-	-	14	-	256	289	261
Tularemia	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	1	1
Typhoid Fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	2	4
Vibrio infection	-	-	-	-	-	-	-	7	-	-	1	-	-	-	-	-	8	7	3
Vancomycin Resistant Enterococci (VRE)	6	4	16	15	6	-	6	733	28	18	121	53	1	16	7	2	1032	867	1084
Yersiniosis	-	-	-	-	-	-	-	6	-	-	-	-	-	-	-	-	6	5	4

Source: ADHS/OIDS/IDES, 04/15/03

Notes: Only incident cases are reported. Strepococcus pneumoniae is lab reportable only. Haemophilus influenzae, Meningococcal, Strepococcal Group B and Strepococcus pneumoniae include invasive diseases only. Non-resident cases have been excluded. One case of Salmonella paratyphi C was reported in 1998.

1 The non-acute hepatitis B case count includes individuals with a positive HBsAg or HbeAg test alone and may include some acutely infected individuals. These counts reflect the year reported or tested and not the date infected. Case counts are not available before 1997.

2 The non-acute hepatitis C case count includes individuals with a positive screening test alone and may include falsely positive individuals. Known risk factors such as intravenous drug use increases the likelihood of these screening tests to be true positives. These counts reflect the year reported or tested and not the date infected. Case counts are not available before 1997.

3 Invasive disease in infants under 30 days of age.

Noteworthy...

National Women's Health Week

Join in celebrating National Women's Health Week May 11-17, 2003. Thousands of women across the nation will take time to focus on their own health. Whether you're a local health care provider, a business leader, a community organization, or a governor, mayor, or tribal leader, there is something you can do to promote women's health.

Kickoff the week by participating in the first ever National Women's Check-Up Day on Monday, May 12, 2003. On this day, community health centers, hospitals, and other health providers across America will encourage women to receive preventive health services. The goal is to educate, screen, and counsel underserved women on preventive health issues and help prevent the onset of targeted health conditions.

For more information about the campaign, go to the *Pick Your Path To Health* website at www.4woman.gov/pypth

Free Cancer Screenings To Promote Breast, Cervical Health

In an effort to detect, and possibly prevent breast and cervical cancers in the early stages, the Arizona Department of Health Service's Well Woman Healthcheck Program (WWHP) has launched its newest efforts to generate awareness for early detection and comprehensive screening services for breast and cervical cancers.

"We want women to overcome their barriers to screening by taking the fear out of cancer diagnosis, lack of transportation, language and cultural differences and lack of physician referral," says Margaret Tate, M.S., R.D., with the Office of Nutrition and Chronic Disease Prevention.

The American Cancer Society estimates 211,300 new cases of invasive breast cancer and 12,200 new cases of cervical cancer among women in the United States will be diagnosed this year. By raising the importance of early detection, WWHP hopes to stop cancer in its earliest, most treatable stage-an average of 1.7 years before a woman can feel the lump. Timely mammography screening among women older than age 50 could prevent 15-30 percent of all breast cancer deaths. Using the Pap test detects not only cancer, but also pre-cancerous lesions which prevents virtually all deaths from this disease.

WWHP provides breast and cervical cancer screenings to women 50 and older who meet certain income guidelines and are uninsured or underinsured. Once a woman qualifies and has been screened, WWHP maintains appropriate referrals, diagnostic follow-up, assurance for medical treatment, and links with key partnerships.

For more information about the statewide program and qualifications, contact the statewide WWHP office at 1.888.257.8502.

Web Picks

Looking for a good Web site to refer patients to about dietary consumption and physical activity? Visit the 5 A Day Web site at *www.5aday.gov*. Look for the Rate Your Habits" hyperlink under the Short Cuts heading, and take a quick quiz to find out how your habits stack up!

Want to learn more about the four steps to fight bacteria from invading food products, kitchen surfaces, knives and other utensils? Visit the U.S. Partnership's Food Safety for Education Web site at *www.fightbac.org*. There you'll find out why the words Clean, Separate, Cook, and Chill can make all the difference in keeping loved ones safe from foodborne illness.

Need to find a recent journal article, but can't recall which issue it was in? Want to find out about the latest medical research programs? You'll find all that and much more in the world's largest medical library online at *www.nlm.nih.gov*.

CDC Lab Sequences Genome of New Coronavirus

The Centers for Disease Control and Prevention (CDC) announced that it has sequenced the genome for the coronavirus believed to be responsible for the global epidemic of severe acute respiratory syndrome or SARS. The CDC sequence is nearly identical to that determined by a Canadian laboratory in mid-April. The significant difference is that the CDC-determined sequence has 15 additional nucleotides, which provides the important beginning of the sequence, CDC scientists said.

The results came just 12 days after a team of 10 scientists, supported by numerous technicians, began working around the clock to grow cells taken from a throat culture taken from one of the SARS patients in Vero cells (African green monkey kidney cells) in order to reproduce the ribonucleic acid (RNA) of the disease-causing coronavirus.

Identifying the genetic sequence of a new virus is important to efforts to treat or prevent it, said Dr. Julie Gerberding, CDC director. "Research laboratories can use this information to begin to target antiviral drugs, to form the basis for developing vaccines, and to develop diagnostic tests that can lead to early detection."

Pediarix™ Approved for Use in Vaccines For Children Program

On February 26, 2003, the Advisory Committee on Immunization Practices (ACIP) approved the inclusion of the DTaP-HepB-Inactivated Poliovirus Vaccine Combination (Pediarix™) in the Vaccines for Children (VFC) Program.

Pediarix™ is not approved for the hepatitis B vaccine birth dose and cannot be given to infants under 6 weeks of age or individuals 7 years of age and older. This vaccine may be used when administration of any component of this combination vaccine is indicated for the primary series. A brief summary of the dosing schedules for each vaccine as a component in the combination is as follows:

1. **DTaP Component of Pediarix™** can be used for the 1st, 2nd, and/or 3rd doses of DTaP if the child is scheduled to receive the other components of the combination and if the other components are not contraindicated.
2. **Polio Component of Pediarix™** can be used for the 1st, 2nd, and/or 3rd doses of polio if the child is scheduled to receive the other components of the combination and if the other components are not contraindicated.
3. **Hepatitis B Component of Pediarix™** is not approved for the hepatitis B vaccine dose administered at birth. After the single antigen hepatitis B vaccine is given at birth, an additional 3 doses of a hepatitis B containing combination vaccine can be given to complete the series starting after 6 weeks of age (preferred option), if the infant is scheduled to receive the other components of the combination vaccine, and there are no contraindications to any of the components.

For adequate immune response, the last dose of hepatitis B vaccine should be given at (24 weeks of age and, therefore, this combination vaccine should not be administered as a complete primary series on an accelerated schedule at 4 week intervals for prevention of pertussis. The 3rd dose of Pediarix™ should be given at least 16 weeks after the first dose, preferably at 6 months of age but not before 24 weeks of age.

When vaccines are provided the Vaccines for Children (VFC) Program through CDC contracts, all providers must abide by the terms and conditions of the contracts. It is not permissible to utilize these vaccines outside the formulations, ages, dose regimens or other conditions established in CDC's contracts.

Diagnosis, Treatment Essential to Combat Congenital Syphilis

by Bogomil Djambazov and Laura Erhart

Congenital syphilis cases are down in Arizona from 32 in 2001 to 19 in 2002, all of which were in Maricopa County. This rate of 22 per 100,000 live births in the state (34 per 100,000 births in Maricopa County) still ranks us poorly, however, and causes a significant disease burden. Congenital syphilis causes spontaneous abortions, stillbirths and multi-system disorders, and is entirely preventable.

In Arizona, most missed opportunities to prevent congenital syphilis appear to be due to either failure to receive prenatal care or failure to be screened for syphilis at the first visit or the third trimester. From 1998 to 2002, approximately 60% of the mothers who gave birth to a congenital syphilis child in Arizona reported receiving no prenatal care. The same percentage were in the19 to 24 age group.

CDC recommends syphilis testing for all women during the early stages of pregnancy and a subsequent test in the third trimester among women at high risk and women in areas where syphilis prevalence is high. Women who deliver a stillborn infant after 20 weeks' gestation should also be tested. Syphilis screening should be offered in emergency departments, jails, prisons and other settings.

Bogomil Djambazov and Laura Erhart are epidemiology specialists in the ADHS Office of Infectious Disease Services. They can be reached at 602.230.5932.

ADHS Web Site Gets Face-Lift

The Arizona Department of Health Services Web site (*www.hs.state.az.us*) unveiled its new look in March, sporting a fresh design and some new tools to make navigation easier. Visitors to the site now can find topics through a detailed A-Z Index listing or can use the new Search engine to pinpoint their desired topic.

Prevention bulletin

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Prevention Bulletin Reader Survey

Dear Reader:

We'd like to know if we are providing you with the kind of information you need and want. Therefore, please take a moment to fill out and return this short survey. Your input is important to us. Results will be printed in a future issue of *Prevention Bulletin*. Please fax completed survey to Courtney Casillas at 602.364.0844. Thank you.

1. How many articles do you read on average in each issue of *Prevention Bulletin*?
   ❒ Almost All ❒ More than half
   ❒ Less than half ❒ None
2. Do you feel that the articles meet your needs?
   ❒ Almost always ❒ Usually
   ❒ Seldom ❒ Never
3. Articles are generally:
   ❒ Too long ❒ Too short ❒ Just right
4. What type of information are you interested in receiving from the Arizona Department of Health Services that does not currently appear in *Prevention Bulletin*?
5. What type of information is now included that you would like to see omitted?
6. Do you wish to continue receiving *Prevention Bulletin*?
   ❒ Yes ❒ No
   (If no, fill out area below or fax copy of mailing label on current newsletter.)
7. Prevention Bulletin is available online for viewing on the ADHS Web site. If made available, would you be interested in receiving an email alert when *Prevention Bulletin* is posted INSTEAD of receiving a printed copy? ❒ Yes ❒ No

   If yes, please provide email address (print clearly):

   _____

Your name *(optional, unless you wish to be removed from mailing list):*

Name: _____

Organization: _____

Address: _____

_____