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National Center for Chronic Disease Prevention and Health Promotion

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Special Focus: Health Promotion and Disease Prevention Research Centers Program

Prevention Research Centers Begin a New Era

Before the 105th Congress adjourned last year, legislators cast a vote for a healthy population by reauthorizing the Health Promotion and Disease Prevention Research Centers (PRC) Program. This CDC-administered program provides core funding to a distinguished set of academic institutions uniquely qualified to conduct community-based prevention research.

Originally authorized in 1984 and first funded two years later, the program is now approved through fiscal year 2003, and $13.5 million was appropriated for the first year of its new phase. Twenty-three institutions, each focusing on a distinct core theme, now constitute the program (see page 3.)

"The PRC Program is CDC's largest investment in extramural research," said Jeffrey P. Koplan, MD, MPH, Director, CDC. "The program has evolved from a set of three centers that tested the concept to a national network for applied research."

Each center is affiliated with a school of public health, medicine, or osteopathy. Applicants for the program propose a core research theme that captures a public health problem of particular concern. Review panels, both external and internal to CDC, evaluate the proposals on several dimensions, including creativity and innovation in research methodology and the ability to forge and sustain quality relationships with defined communities and partnerships with diverse health-related agencies and organizations.

For example, two centers work almost exclusively with American Indian communities, and a third is devoted to Appalachian populations. Another center focuses on senior adults in urban care centers, and other centers are concerned with issues such as tobacco use, unintended pregnancy, and violence among adolescents of different ethnic and socioeconomic backgrounds.

"Through the use of community advisory boards, collaborative research projects with local agencies, and other mechanisms, the centers build what might be called 'family ties' that foster communities' participation in health promotion interventions. The centers can reach Americans in ways that CDC, as a federal agency, is hard pressed to do," Dr. Koplan reflected. "The close interaction between centers and their communities is a model of public health research in which interventions are tested, evaluated, adapted, and replicated. CDC is proud to be the catalyst for this endeavor."

The program is appreciated not only for its access to communities in need but also for its access to communities of multidisciplinary faculty having expertise in the range of knowledge and skills needed to address health behaviors,

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention

Commentary Commentary Commentary

The Case for Extramural Prevention Research

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Our efforts to devise effective programs, strategies, and initiatives for preventing heart disease, cancer, diabetes, and other chronic diseases and conditions require innovative thinking to produce the hoped-for, widespread results in reducing their prevalence. Although we have begun to make significant gains, chronic diseases continue to take a heavy toll on our nation.

For our disease prevention and health promotion efforts to be successful, we have to conduct prevention research on a wider-than-ever scale and fully investigate diverse methods, including those that draw on behavioral science and those that raise consciousness. We have come to understand that researching prevention to determine the best strategies involves many partners in different spheres—the public at large, policymakers, health care providers, state and local health departments, and academic centers.

During the early 1980s, D. A. Henderson, MD, MPH, and other key figures working under the aegis of the Association of Schools of Public Health were among the first to recognize the need for extramural research to further the prevention agenda. They and others, including former CDC Director, William H. Foege, MD, MPH, worked to create what is now called the PRC Program.

From 1986 to 1996, the number of centers grew from 3 to 14. Thanks to continued support for this program, the number of centers has reached 23. This continued expansion has allowed the program to reach more and more Americans. Although the centers focus on the core themes for which they were selected, they have greatly expanded their capacity to support NCCDPHP initiatives, as well as those from other parts of CDC and DHHS, by conducting special interest projects (SIPs) (see page 20).

As the next era of this program begins, we have the opportunity to further expand the impact and application of prevention research. I see three elements crucial to the success of this initiative: partnerships, prototypes, and patience.

Through partnerships with state, local, and community agencies and organizations, as well as networking among the centers, the PRC Program has become much greater than the sum of its parts. CDC administers the cooperative agreements that guide the program, and the academic centers (within schools of public health, medicine, or osteopathy) conduct the research and interventions. But conducting research is not the point of this endeavor; rather, delivering real, workable solutions to help people in communities improve their health and well-being is the crucial element of this partnership. Therefore, as the research proliferates, we must remain true to our responsibility to share interventions and findings with all partners, including our state and local health departments and our community sources. We must continue to draw on these sources for invaluable information about how to shape the research itself.

By having added centers that bring new research themes and techniques as well as proven strategies, we sustain a vital, responsive program that can offer prototypes for conducting prevention research in the next century. We must acknowledge, understand, and replicate the multiple, tangible successes that have already resulted from the centers' projects at worksites, at schools in inner cities and on American Indian reservations, and in diverse neighborhoods.

We must remember, however, that prevention research is a long-term endeavor. Assessing needs, changing complex behaviors, and evaluating outcomes all take years, perhaps decades. Improving our communication with health departments and reaching concurrence with community members on their needs takes time. Having a creative, vital extramural prevention research program both to tap into new techniques and ideas and to anchor the working relationships among the many partners will save crucial years for our prevention efforts.

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Centers and Themes

University of Alabama at Birmingham
Center for Health Promotion
Bridging the Gap Between Public Health Science and Practice in Underserved Communities

University of Arizona
Southwest Center for Community Health Promotion
Promoting the Health of Multiethnic Communities of the Southwest

University of California at Berkeley
Center for Family and Community Health
Chronic Disease Prevention: Partnerships for Action With Families, Neighborhoods, and Communities

University of California at Los Angeles
UCLA/RAND Prevention Center for Adolescent Health Promotion and Disease Prevention
Adolescent Health Promotion and Risk Reduction Start at Home

University of Colorado
Rocky Mountain Prevention Research Center
Promoting Healthy Lifestyles in Rural Communities

Columbia University
Harlem Center for Health Promotion and Disease Prevention
Putting Health Promotion Into Action Through Community Collaboration

Harvard University
Harvard Prevention Research Center
Nutrition and Physical Activity in Children and Youths

University of Illinois at Chicago
Health Research and Policy Centers
A Lifespan Approach to Chronic Disease Prevention

The Johns Hopkins University
Center for Adolescent Health Promotion and Disease Prevention
Promoting the Health of Adolescents Through Families and Communities

University of Michigan
Center for Community Collaboration in Public Health Research
Closing Gaps and Improving Health in Partnership With Families and Communities

University of Minnesota
Teen Pregnancy Prevention Center
Teen Pregnancy Prevention and Youth Development

Morehouse School of Medicine
Health Promotion and Disease Prevention Research Center
Risk Reduction and Early Detection in African American and Other Minority Communities

University of New Mexico
Center for Health Promotion and Disease Prevention
Working in Partnership With American Indian Communities to Improve Health and Well-Being

University of North Carolina at Chapel Hill
Center for Health Promotion and Disease Prevention
Improving Community Health Through Workplace Health Promotion

University of Oklahoma
Oklahoma Center for Prevention Research in Native Americans
Promoting Healthy Behavior in Native American Populations

Saint Louis University
Prevention Research Center
Chronic Disease Prevention in High-Risk Communities

University of South Carolina
Health Promotion and Disease Prevention Research Center
Promoting Health Through Physical Activity

University of South Florida
College of Public Health, Department of Community and Family Health
Community-Based Prevention Marketing for Disease Prevention and Health Promotion

University of Texas Health Science Center at Houston
Texas Prevention Research Center
From Healthy Children to Healthy Adults

Tulane Medical Center
School of Public Health and Tropical Medicine Prevention Center
Environmental Agents and the Health of Communities

University of Washington
Northwest Prevention Effectiveness Center
Keeping Older Adults Healthy and Independent by Using Community Partnerships

West Virginia University
Prevention Research Center
Health Promotion and Disease Prevention in Rural Appalachia: Impacting Policy and Practice

Yale University
School of Public Health
Public Health Initiatives Across the Prevention Spectrum

Community Highlights

"Among the 23 prevention research centers combined, several hundred projects are under way," said Patricia L. Riley, CNM, MPH, Director of the PRC Program. "It would be impossible to describe all these activities. Even in categorizing the projects by type of community, methodology, disease, or risk factor, we would lose essential features that make these projects unique and successful."

The features in the articles that follow are representative of the quality of community research in progress and illustrative of the program. The article concerning the advisory board to the Harlem Center for Health Promotion and Disease Prevention describes the depth of community interaction to which all the centers aspire. The story of women involved in worksite health promotion shows the creativity the centers apply in reaching people who might otherwise not be served. The article about Navajo children illustrates the potential of prevention research to alter the health of future generations.

"These are just a few of many dimensions I want to share about the program. CDC commends all the prevention research centers for their judicious use of resources toward furthering public health," Ms. Riley added.

Harlem Residents Foster a Health Renaissance

Harlem is the New York City neighborhood that borders the Hudson and East Rivers between 110th and 155th Streets. But people who live there say that Harlem is a state of mind, embracing a community rich in history, culture, creativity, and activism. Harlem is perhaps best known for its Renaissance Era (1917–1934), when a thriving middle-class society created a mecca for black musicians, writers, and human rights advocates. When the Great Depression struck, however, unemployment soared, and Harlem fell into decline. In the 1960s and 1970s, promises of urban renewal were scarcely realized.

Harlem residents today are still diverse in ethnic heritage and socioeconomic profile. Churches, neighborhood entrepreneurs, and other community groups are renovating homes and encouraging a resurgence in business. About two-thirds of adults in Central Harlem have a high school education or more.

Nevertheless, 41 percent of Harlem residents still live below the poverty level. Continued hope and community pride, which can affect well-being, may be challenging for residents who contend with not only the substance abuse and violence that characterize too many urban communities, but high prevalences of hypertension, asthma, and other chronic conditions as well.

The Mailman School of Public Health of Columbia University was long concerned about the health of its neighbors. But Harlem residents had grown weary of a past in which researchers from many institutions surveyed the Harlem community, returned few benefits to it, and reported results that confirmed only negative stereotypes. As one long-time resident expressed the prevailing sentiment, "If you wanted to put a negative face on a problem, you went to Harlem."

Striking a New Balance

When it was first funded in 1990, the Harlem Center for Health Promotion and Disease Prevention sought to reenter this community in a way that would be positive and supportive and yield tangible results.

"We didn't need a way just to do more research," said Allan Rosenfield, MD, Principal Investigator of the prevention research center and Dean of the Mailman School of Public Health. "We needed a way to apply research to services and thereby meet the needs of the people. For this to happen, the prevention research center became the 'glue.'"

This "glue" binds multiple agencies, including community-based organizations, that work together with the prevention center and the community to identify health priorities and find practical ways to address them. Guidance comes from the community advisory board, a resource all prevention research centers are now required to use.

The advisory board for the Harlem prevention center comprises an impressive number of experts:

- Aissatou Bey-Grecia, Director, Harlem Hospital Injury Prevention Program.
- Goldie Watkins-Bryant, MPH, Project Director, Healthy Start New York City.
- Collin Bull, JD, Attorney-in-Charge, Legal Aid Society, Harlem Neighborhood Office.
- James L. Curtis, MD, Director, Department of Psychiatry, Harlem Hospital Center.
- Sydney Moshette, MSW, Director (retired), Reality House, Inc., an HIV primary care center serving more than 700 outpatients per year.
- Muriel Petioni, MD, Chair and Founder, Friends of Harlem Hospital Center, Inc., retired after more than 35 years of family practice in Harlem.
- Congressman Charles B. Rangel (designee: Donald Covington).
- Stephen Robinson, MD, MPH, Former Director, Physician's Assistant Program, Sophie Davis School, City University of New York.
- Peggy Shepard, Executive Director, West Harlem Environmental Action (WE ACT).

These compassionate, well-respected, and knowledgeable persons represent many of the main institutions and interest groups in the Harlem community.

"The advisory board meets at least quarterly," explained Alwyn Cohall, MD, Director of the Harlem prevention center, "but we call on individual members all the time. We intend to broaden our sense of who the Harlem community includes by broadening representation from additional community groups. For example, we would like members to represent the arts, the educational community, and some of the main health-surveying institutions."

Five members of the community advisory board to the Harlem Center for Health Promotion and Disease Prevention convene at a meeting last year. From left, Sydney Moshette, MSW; Goldie Watkins-Bryant, MPH; Muriel Petioni, MD; Collin Bull, JD; and Aissatou Bey-Grecia.

Developing a Dynamic Relationship

Interaction between the center and the advisory board is lively, but it took time for a healthy marriage to mature. "At first, we were somewhat passive," Dr. Petioni said, "but once we decided we had to make the research more practical, we started to participate more. If research results aren't implemented, what's the point of the research?"

During several days of structured retreats, the advisory board and prevention center staff reexamined the center's mission and the community's most pressing needs. The prevention researchers

shared a wealth of data—gained largely from the 1990–1994 Household Survey Study, a large field study conducted by the prevention research center, in which more than 700 households in Harlem were visited and information was gathered about residents' health status. The advisory board helped pinpoint health priorities and set the agenda for future prevention research and intervention.

"Many of the people we see for other reasons make us aware of health issues," Mr. Bull commented. "The neighborhood office of the Legal Aid Society serves more than 4,000 people a year who are diverse in age and type of problem. Many of these people have consumer issues that cross boundaries into health issues."

"If research results aren't implemented, what's the point of the research?"

Because of their place in the community, the board members are well equipped for helping transform ideas into interventions. Accomplishments of prevention research have been made in tobacco control, physical activity, injury control, and environmental quality. For example:

- Enforcement of laws prohibiting sales of cigarettes to minors has been strengthened.
- Women who reported feeling uncomfortable walking alone for exercise have enrolled in walking groups or aerobics classes at community facilities.
- Playgrounds have been built or refurbished in schoolyards and parks to improve children's safety.
- Residents are enjoying the 125th Street Oasis, a garden and performance space that humanizes a busy commercial area.

The latter project was accomplished by WE ACT's Earth Crew, a cadre of neighborhood youths, aged 13–17 years, trained by the organization in environmental education and community service (see page 7).

Educating Community Leaders

In addition to helping select research priorities, the board advises on how to inform constituents and their representatives. "We want to share health statistics with elected officials," Dr. Petioni said, "but interpretation is key. Health may not seem like a priority here because we're poor, and many basic needs aren't met. Yet many conditions result from poverty, which is hardly understood. Many behaviors, such as alcohol and drug abuse, result from desperation and frustration. We know that stress increases hypertension and diabetes, and stress is often greatest among the poor. Nevertheless, we try to accentuate the positive. For example, although unemployment is high in Harlem, the statistics show that more people in Harlem are working than are not."

Members of the advisory board lend their insight to untangling the web of socioeconomic interactions that affect health and help leaders understand those interactions.

Community interaction takes time, money, and personnel, Dr. Rosenfield reminded, but the returns are great. "We dedicate resources for meeting with residents, disseminating research findings, and contributing to community health initiatives," Dr. Rosenfield said. "We also invest in training students and health care workers. When we develop new projects, we involve community members."

"Giving meaningful input is harder than being passive," Ms. Bey-Grecia said. "Because we want a good advisory board and a good prevention center, we have to deal with hard issues. We are entrusted with the responsibility not to think about personal gain but how greater gain in the community can be realized."

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Uptown Health Risks Are Curbed

West Harlem Environmental Action (WE ACT) seeks to improve quality of life and secure environmental justice for residents of northern Manhattan. Peggy Shepard, WE ACT's Executive Director, cataloged the area's environmental stressors. "The neighborhoods here are surrounded by three major highways, two sewage treatment facilities, two marine garbage collection transfer stations, a major truck transportation route, a diesel-fueled rail line, and six diesel bus depots. We try to raise consciousness among residents about these health hazards and facilitate public policy change."

Earth Crew members at headquarters (from left): Kevon Williams, Damian Gaillard, Samantha Garrett, and Carlos Jusino.

The Environmental Health Leadership Training is one way environmental awareness is raised among residents of Harlem and Washington Heights. Participants in this six-session training program take a "toxic tour" of neighborhood sites, learn about lead poisoning and possible contaminants in the water supply, focus on air pollution and control, and explore toxins within the home that may contribute to asthma and indoor air pollution.

"WE ACT is a fine example of collaboration among organizations," said Alwyn Cohall, MD, Director of the Harlem Center for Health Promotion and Disease Prevention. "The leadership training program, for example, is a partnership among WE ACT, the Environmental Protection Agency, the National Institute for Environmental Health and Safety's Center for Environmental Health in Northern Manhattan at the Mailman School of Public Health, and the Harlem Prevention Research Center."

WE ACT also conducts conferences on lead poisoning, produces a cable television program on environmental issues, and offers the Earth Crew Youth Leadership Program and the Environmental Worker Training Program. The latter recruits and trains unemployed young adults and helps them develop basic construction skills and gain certification in environmental remediation work that may lead to employment.

The youths in the Earth Crew receive a small stipend for contributing to some of the prevention center's research and demonstration projects. For example, the Earth Crew monitored traffic flow and air pollution particulates for studies of exposure to elemental carbon that led to local advocacy for natural gas buses. The crew also administered questionnaires in a pilot study of exposure to diesel exhaust, which is associated with respiratory diseases, cardiovascular disease, and cancer.

"What is so impressive about WE ACT," Dr. Cohall said, "is its investment in young people. Programs that empower youths are endeavors the prevention research center wants to support."

Carlos Jusino, a college sophomore, has been involved in WE ACT since his early high school years. "I first joined WE ACT to be with friends and gain a stipend. But I soon took the program to my heart. I became informed and aware of my environment," Mr. Jusino said. Now a student of computer science and environmental science, Mr. Jusino recently represented WE ACT at a conference on the use of computers for social change. "I can see myself writing software for grassroots organizations in environmental change. WE ACT gives you leadership skills and allows you to see ways within yourself to grow and contribute." Mr. Jusino began work with WE ACT as an Earth Crew member, progressed to Peer Leader, and now serves as Assistant Youth Coordinator and coordinator of WE ACT's geographic information system, which maps polluting facilities and health indices.

Taking Health Messages to North Carolina Workplaces Effectively Reaches Women

Randa Corporation, a production business that specializes in preparing neckties for retail stores, is a modern facility located on the outskirts of Kinston, North Carolina, and most of the employees are women. In this largely rural section of the state, access to information about healthy behaviors is inadequate, and many barriers emerge to practicing these behaviors. Many women who live and work in the area are at a higher than average risk of developing chronic diseases such as heart disease, cancer, or diabetes.

Participants in Health Works for Women *provide each other support and encouragement.*

However, within the last year, many of these workers have become avid walkers, many now opt for low-fat foods for lunch—including lots of fruits and vegetables, and several of them have stopped smoking. "Since I stopped smoking, I started walking," Doressa Uzzell, one of the nearly 100 blue-collar women employees at Randa, said. "When we walk, we laugh and enjoy ourselves."

Ms. Uzzell and a group of her co-workers are participating in *Health Works for Women*, an outreach program that targets blue-collar women in small- to medium-sized workplaces (fewer than 200 employees) and that was developed by the Center for Health Promotion and Disease Prevention (CHPDP), University of North Carolina at Chapel Hill. "We are striving to reach an often overlooked population of employees who work in small companies that have not previously developed or been able to sustain a worksite health promotion program," explained CHPDP's Salli Benedict, MPH, CHES. "The workplace is the most convenient, logical place for these women to receive health care messages."

Early Indications Point to Risk Reduction

Health Works for Women focuses on increasing physical activity, improving nutrition, decreasing smoking, and increasing screening for breast and cervical cancer among the program's participants. Baseline and 6- and 18-month follow-up surveys were conducted at all worksites to measure the effectiveness of workplace interventions. "Few studies have attempted to collect this kind of information about health interventions for blue-collar women," Ms. Benedict noted.

At four worksites, including Randa, the intervention involved two key components: recruiting and training 104 lay health advisors and using a computer program to deliver customized, printed messages. At five worksites, which served as controls, a delayed intervention consisted of one tailored message following a second survey.

Preliminary findings from 6- and 18-month follow-up surveys indicate improved levels of physical activity and healthy eating. Women at the intervention workplaces increased their levels of physical activity (as measured in METS—

metabolic equivalents of energy expended per hour of exercise), unlike women at the comparison worksites, according to Marci K. Campbell, PhD, Principal Investigator, CHPDP. Women at the intervention worksites also increased their fruit and vegetable intake, while women at the comparison sites did not. Dietary fat intake decreased modestly among both groups. No measurable effect was seen for smoking, Dr. Campbell noted, adding that few women showed strong interest in changing that behavior.

Setting the Stage for Behavior Changes

"One of the first things we did was to conduct focus groups with the workers. During the first session, we just talked with them to learn which issues were important to them and to convey that we were going to conduct a responsive program, not a canned program," said Dr. Campbell. Following these focus group sessions, prevention center staff recruited volunteers from the workplace, developed materials, and held training sessions for the lay health advisors. At Randa Corporation, two groups of lay health advisors participate: the "Upbeats" consists of about 20 women from the production line, and the "Nutty Buddies" are a dozen women from Randa's office and management staff.

Each group has met every other month with the *Health Works for Women* team members during the past 18 months. At a typical hour-long session, the lay health advisors shared fresh vegetables, fruits, and juices before engaging in role playing and learning about cancer prevention, breast self-examination, and when to request Pap tests.

Lay Health Advisors Embrace Their Role

The concept of training women to serve as advisors for others by first making them informed about health and lifestyle issues has not only taken root, but has flourished. "As soon as this program started, I thought it was superb," said Marion Watson, a 17-year Randa employee who is a member of the office staff. "The information about women and their health is great. Before *Health Works for Women* came to Randa, I was trying to do things to improve my health on my own." Ms. Watson credits the program with having given her guidelines, and she credits group support for the encouragement to improve her diet, start walking for exercise, stop smoking, and reduce stress.

Ruth Wiggins, a Randa production line worker, concurred. "This is the first program I've been in that I've stayed in," she said. "I thought I already knew how to eat and exercise, but I didn't. My lifestyle has changed in many ways. For example, now I use a treadmill every day." "Upbeats" member Josephine Wallace said that *Health Works for Women* has helped her quit smoking, change her diet, and start exercising. "I exercise every day now. I walk and go to aerobics twice a week. I feel positive about myself," she added.

These women feel comfortable in their roles as ambassadors for healthy behaviors. "While we are working on the floor, we share recipes, we pass out literature, and we talk to the other workers about health matters," Ms. Wiggins explained.

Dr. Campbell asserts that the social support and trust created by working together contributes to making such interventions successful. Moreover, the benefits from this type of intervention reach beyond the worksite, according to Ms. Benedict. Sharing information from a worksite intervention with family

"The workplace is the most convenient, logical place for these women to receive health care messages."

members, friends, and fellow church members extends the reach of worksite health promotion into a community.

Evaluating and Expanding the Program

Program staff continue to collect and evaluate quantitative and qualitative data from the surveys and interviews with participants. Indications so far are that the program succeeded in helping participants improve their levels of physical activity and their dietary choices. Workplaces reported high satisfaction with the program and the desire to continue their involvement. As the program concludes, prevention center staff have been evaluating the interventions and results to help shape future programs.

"We need to take what we have learned and try our approach in smaller companies and in different types of industries," Dr. Campbell said. "One of our future directions is to expand the range of this model to include interventions that can lead to changes in health behaviors within organizations and communities."

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American Indian Communities Seek to Improve Their Children's Health

Residents of Crownpoint, located on the Navajo Indian Reservation in northwestern New Mexico, saw a pattern. Diabetes, already prevalent in the native population, is occurring in younger and younger generations. Children in the elementary schools were learning that they have diabetes, a chronic disease that puts them at risk for debilitating complications as they mature. Much of this increase in prevalence is attributed to childhood obesity, a consequence, at least in part, of inadequate physical activity.

In a distant community like this one, children may not have a place to go for planned activity, such as the ballfields of the suburban little league. Some children ride the school bus for two hours each way, which allows little time for active play. Other children live in small towns or at boarding schools where facilities for physical activity are scant. In addition, as successive generations have become further removed from the native lifestyle, certain benefits have been lost.

"Almost all traditional ways of life had something physical attached to them," said Chenoa Bah Stilwell, MS, a university research assistant of Navajo descent. "As a child, I helped herd sheep. Climbing, running, and doing livestock chores were my physical activities. In learning to be a weaver, I walked to collect plants for dyes." Ms. Stilwell added that education is stressed by many families. Although school achievement is important, the children's lives may not be balanced in the most healthful way.

Calling on Colleagues

The keen awareness of diabetes and the complex reasons for it prompted teachers, parents, and community health workers from the reservation to seek innovative solutions, which included asking for involvement from the University of New Mexico's Center for Health Promotion and Disease Prevention.

"The relationship between researchers here and American Indian communities goes back several decades," said Sally Davis, PhD, Center Director. "We strive to maintain a positive, trusted, and credible relationship so that community members who identify health needs will see us as a partner. The Crownpoint community repeatedly spoke with us about diabetes and something for its kids."

When it was first funded in 1995, the prevention research center was seeking to establish a demonstration program for rural American Indian communities that promoted physical activity, a healthful diet, and tobacco avoidance. Thus, the kind of relationship Dr. Davis described was mutually beneficial and representative of the synergy that occurs between many prevention centers and communities. The centers fulfill their mission to develop and evaluate methods for achieving health objectives. The lessons learned from demonstration and intervention projects in one community are often translatable to others, and such dissemination increases the efficiency with which successful methods are applied.

Kids Get Active

Following suggestions from the Crownpoint community, the prevention researchers investigated and then recommended the Sports, Play, and Active Recreation for Kids, or SPARK, curriculum, developed by James S. Sallis, Jr., PhD, in a research study funded by the National Heart, Lung, and Blood Institute. Data on height, weight, and body fat are collected in the fall and spring from each child who participates in the program, which prescribes physical activity during the school year.

"In many states, school standards for physical education (PE) are uneven," Dr. Davis said, "and school time for PE and recess has dwindled. We thought it important to get PE back into the school, and it was largely through the school that we could reach these children." The SPARK curriculum was introduced at Crownpoint Elementary School in the 1995–1996 school year.

Jill Henwood, MS, a sixth-grade teacher who uses SPARK, commented on

Simple equipment and noncompetitive games let all children be involved in exercise.

"We strive to maintain a positive, trusted, and credible relationship so that community members who identify health needs will see us as a partner."

the appropriateness of the curriculum. "The activities are noncompetitive and interesting and get the children moving. The equipment is inexpensive and simple—balls, hula hoops, and jump ropes—so we can have enough for all the children. Our cafeteria doubles as a gym, and it is the only space for exercise in bad weather. Some exercises can be done indoors. And the curriculum is 'friendly' to teachers who are not very active themselves. Because we lack a PE teacher, gym space, and equipment, these considerations are important."

Testing feasibility is crucial to the success of any intervention. "A demonstration project is necessary to get feedback on whether the plan is even possible. Is the curriculum accepted by teachers? Is it supported by the principal? Do the children learn skills they can continue at home? Is the program sustainable even in schools with high teacher turnover?" Dr. Davis asked.

Navajo children engage in exercises that may help lower their risk of diabetes.

So far, the curriculum has proven feasible. Alberta Becenti, MPH, Director of Community and Preventive Health, Crownpoint Healthcare Facility, Indian Health Service, talked about expansion. "Three other elementary schools in this corner of the state began SPARK in this school year. The prevention research center provided the support for teacher training, the purchase of materials and equipment, and the Community Coordinator, Charlotte Morgan, who helps teachers with not only this curriculum but other physical activity events throughout the year."

Sustainability Is Key

Dr. Davis cites this project as an example of a new kind of interaction between researchers and communities. The community identifies health needs, and prevention researchers seek out ways to serve those needs. "We try to find resources appropriate for the community, not a community for available resources. We remain connected to and integrated with existing programs and make use of what is available in a community. We question anything that is not sustainable or replicable. A long-term commitment is essential. If we had pulled out of the relationship at any time since the early 1970s, we wouldn't have been invited—and we wouldn't be *able*—to go back."

Communication is also key to the success of community research and intervention. Certainly, in learning about type 2 (non–insulin-dependent) diabetes among the children, the prevention researchers checked the scientific literature to verify the association between obesity and diabetes and followed Indian Health Service and other local pediatricians' reports of an increased prevalence of type 2 diabetes among 8 to 11 year olds in this population. Researchers are quick to add, however, that informal information and qualitative data were equally important, particularly because data are sparse and because both language and cultural differences are involved.

To sustain and enhance communication and trust, the prevention center sponsored the Eastern Navajo Nation Health Research Conference in September 1997 in the Crownpoint community and just repeated the conference for the Shiprock Area of the Navajo Nation. At the two-day conference, researchers

shared information with community members, many of whom staff schools, clinics, and service agencies on the reservations. In learning about research processes and results from multiple projects, attendees expanded their capacity for their own work.

Interactions such as these are also crucial to researchers' staying tuned to the unique dynamics of American Indian communities. For example, researchers are reminded about how cultural values influence self-perceptions of health; how attitudes and expectations affect receptivity to services and interventions; how lack of transportation can impact the seeking of health care in an area where driving distances are vast; and how important word of mouth is in some native communities that listen for news from the *kukadze'eta*, or town crier.

"Researchers must continually remember that working with American Indian communities means working with distinct tribal nations governed by their own laws and systems," Dr. Davis explained. "Nonnative researchers serve as ambassadors of their own nation, committed to maintaining good relations. We often recall an Apache saying that friendship is like buckskin: it takes a long time to make it soft and pliable."

For further information, contact Sally Davis, PhD, Principal Investigator, or Janice Thompson, PhD, Exercise Physiologist and Staff Specialist, Center for Health Promotion and Disease Prevention, School of Medicine, 2701 Frontier NE, Surge Building, Room 251, Albuquerque, NM 87131-5311; 505/272-4462; fax 505/272-4857; E-mail smdavis@unm.edu.

PRCs Begin a New Era

► *CONTINUED FROM PAGE 1*

cultural norms, socioeconomic determinants of health care, and other factors.

Allan G. Rosenfield, MD, President of the Association of Schools of Public Health, Dean of the Mailman School of Public Health of Columbia University, and Principal Investigator of the Harlem Center for Health Promotion and Disease Prevention, which has been a member of the PRC Program since 1990, commented on the networking among professionals.

"Our projects have covered environmental hazards, asthma, preventing cigarette sales to minors, and risks—such as racism—to premature mortality," Dr. Rosenfield recounted. "For such complex projects, multifaceted expertise is needed. The Mailman School of Public Health embodies research capacity in epidemiology, biostatistics, behavioral science, and other crucial areas. And the school serves as a conduit for investigators in other disciplines."

Patricia L. Riley, CNM, MPH, Director of the PRC Program, noted that the program has become a mechanism through which other agencies and organizations can direct funds for complementary research.

"In an era of competitive research funding," Ms. Riley commented, "it is ever more important that programs and agencies collaborate and communicate. Programs like this one provide opportunities for sharing resources." In this new program phase, Ms. Riley continued, "as the number of centers has grown, new research themes have been added, and more research institutions make use of the program, CDC's initial investment continues to multiply."

For more information, contact Patricia L. Riley, CNM, MPH, Director, Prevention Research Centers Program, NCCDPHP, Centers for Disease Control and Prevention, Mail Stop K–30, 4770 Buford Highway, NE, Atlanta, GA 30341-3717; 770/488-5395; E-mail pyr0@cdc.gov.

> *"... the centers build what might be called 'family ties' that foster communities' participation in health promotion interventions."*

Prevention Research Centers Program Credits ASPH's Vision

A health initiative that connected crucial scientific and biomedical research to the practice of everyday public health began taking shape in the early 1980s. Michael K. Gemmell, CAE, Executive Director, Association of Schools of Public Health (ASPH), recalled that Robert W. Day, MD, PhD, then Dean of the School of Public Health, University of Washington, and President, ASPH, "spoke with William H. Foege, MD, MPH, who was the CDC Director at that time, about this idea, but the timing was not right."

The next ASPH president, D. A. Henderson, MD, MPH, was also then Dean of the School of Hygiene and Public Health, The Johns Hopkins University. "When I became dean [1972], it seemed to me that the academic public health centers were becoming increasingly divorced from the real world of public health. Some people were concerned that research efforts were even becoming precious and irrelevant," Dr. Henderson, currently University Distinguished Professor, The Johns Hopkins University, and a former World Health Organization scientist, noted. "I thought how easy it is to become isolated and to rely entirely on one's own expertise rather than reaching out to involve the best minds, wherever they might be."

Dr. Henderson worked with The Johns Hopkins University and the Andrew Mellon Foundation to set up a Health Program Alliance Office (1978) that would "bring faculty and students to the public health bedside. It turned out to be more difficult than we had expected, but gradually the program made headway as we worked with primarily state, city, and voluntary agencies." Dr. Henderson believed that other schools of public health would benefit from being part of this program.

The program's advocates knew that its survival would require public funding to operate on the scope needed to reach the nation's communities. Largely through the efforts of William Bridgers, MD, founding Dean of the University of Alabama School of Public Health, and ASPH President from 1982–1986, and Mr. Gemmell, the groundwork for the

Prevention Research Centers (PRC)

1981: *Public health leaders propose a network for applied public health research.*

1984: *Congress authorizes the Secretary of Health and Human Services to engage academic health centers for this purpose. CDC is identified as administrator of the activity.*

1986: *PRC Program takes shape as the first three research centers are funded.*

1990: *Program grows to include seven research centers.*

1991: *Annual PRC conferences begin.*

1993: *Program expands to nine research centers. Supplemental funding mechanism is introduced for Special Interest Projects sponsored by CDC's centers, institute, and offices, and by other federal agencies.*

proposal that authorized the prevention research centers was advanced in Congress.

Prevention Research Was Slightly Ahead of Its Time

Initially, the concept was not clearly understood. According to Dr. Bridgers, "Prevention research was not viewed as a unique and potentially powerful arrow in the quiver of congressionally mandated wars against cancer, stroke, heart disease, and other dreaded diseases." In addition, "Few insurers, including Medicare, paid much attention to the potential power, the primacy of prevention," he said.

The program's advocates in the schools of public health had their own vision. "The schools of public health were then, have been, and remain the prime resources for research and application of findings in disease control and prevention," said Dr. Day, currently President and Director Emeritus, Fred Hutchinson Cancer Research Center.

The idea was to make a competitive award that would emphasize applied research in disease prevention and control to schools of public health. "If the award size was substantial, then these grants would help orient much of the research activity in the schools of public health toward disease prevention and control," Dr. Day said.

"Our thinking was that if we could focus on the right kinds of studies," Dr. Bridgers noted, "we might devise strategies to intervene before a risk, before symptomatic disease." The concept included epidemiologic investigations, studies of methods for early interventions, screening for risks, and retrospective and prospective study designs for high-risk groups and communities. "We had the beginnings of a definition for 'prevention research' that was understandable to the layman and that helped crystallize the idea of a cross-cutting research center," he added.

Program Has Steadily Grown

On October 30, 1984, the only new public health program enacted during the mid-1980s was established as Public Law 98-551: "The Secretary shall make grants or enter into contracts with academic health centers for the establishment, maintenance, and operation of centers for research and demonstration with respect to health promotion and disease prevention."

Program Over Time

1994: *Four additional centers bring prevention research to tribal governments, Appalachia, and the Ozarks; brings total to 13.*

1995: *National Institutes of Health selects PRC Program for community prevention component of Women's Health Initiative. Centers collaborate to form the Tobacco Network.*

1996: *One center is added to address the national health concern about teenage pregnancy. Centers collaborate to form the BRFSS Network (Behavioral Risk Factor Surveillance System) and the School Health Network.*

1997: *Institute of Medicine publishes its expert committee review of the program. Centers collaborate to form the Women's Cardiovascular Health Network and the Oral Health Network.*

1998: *Program is reauthorized by Congress through fiscal year 2003. Nine centers are added to expand regional scope and broaden research themes; brings total to 23.*

1999 *Centers convene to coordinate research agenda for the current five-year program phase.*

"Much remains to be done—including more centers, more studies—if prevention's full potential is to be realized."

CDC, which had an infrastructure for working through state and local health departments, was named the lead agency.

Congress first allocated funds in 1986 for three institutions, and by 1993, the program had expanded to nine university affiliates. Its core funding has grown from $1.5 million to fund three centers in 1986, to $8.3 million to fund 14 centers that managed more than 160 projects in 1997, and most recently to $13.4 million to fund 23 centers for the current fiscal year. This core funding supports research and demonstration projects related to each center's theme. Each center conducts at least one demonstration project with a state or local health department or a board of education.

During the tenure of former CDC Director and current Surgeon General David Satcher, MD, PhD, the program expanded to include 14 academic partners. Since 1993, the scope of the centers' activities has expanded to include special interest projects, or SIPs, which add a new revenue stream to the core funding and allow the participating researchers to broaden the scope of their activities to address multiple public health needs. (For a list of current SIPs, see page 20.)

For example, among these SIPs is a five-year partnership with the National Institutes of Health that focuses on health issues of older women. "This collaboration uses the program's resources and broadens the program," according to Patricia L. Riley, CNM, MPH, Director of the PRC Program. "The Women's Health Initiative is the most significant research allocation in our agency that focuses on older women," she added. (For more about this initiative, see page 22.)

Recently, CDC called on the Institute of Medicine to conduct an external, independent evaluation of the program. That report commends the progress made but adds that "By strengthening the program, the prevention research centers can contribute even more to local, state, and national efforts to improve the health of Americans." (For more on this report, see page 17.)

William Bridgers, MD (left), and Michael K. Gemmell, CAE, are two of the PRC Program's founders recognized at the Ninth Annual Prevention Research Centers Conference in February 1999. Not available to receive the awards were Robert W. Day, MD, PhD, and D. A. Henderson, MD, MPH.

Continued Support and Expansion Will Bolster PRCs

To remain successful, the PRC Program seeks to expand its capacity while keeping true to its intent. Dr. Henderson believes that a tripartite program involving as equal partners the CDC, the academic centers, and the state and local health departments would best foster the well-being of public health in America. Dr. Bridgers cautions that "Much remains to be done—including more centers, more studies—if prevention's full potential is to be realized."

In commenting on the program, Darwin R. Labarthe, MD, PhD, Co-Director, Texas Prevention Research Center, University of Texas Health Science Center at Houston, stressed that the PRC Program could become "a central mechanism for implementing a greatly expanded research agenda at CDC." Dr. Labarthe urges that the core funding for each center match the original congressional intent. As Mr. Gemmell states, "the pendulum is swinging toward population-based research, which should spell a bright future for the prevention centers program."

Institute of Medicine Speaks to the Prevention Centers' Future

"As the PRC Program begins a new phase, it is at a crucial turning point," Patricia L. Riley, CNM, MPH, the program's director said. "CDC anticipated this and asked the Institute of Medicine (IOM) to review the program in 1995 to evaluate the quality of its projects and CDC's management of it."

A committee of health experts (see page 19) was convened for this independent evaluation, and the results were published in 1997. The committee, which included leading academicians and public health officials, concluded that the program had made substantial progress and proposed recommendations to strengthen the program for the future.

"The report is much more than an evaluation," Ms. Riley said. "It is a distinguished committee's expert contribution to the program's future. Many recommendations were embraced by the reviewers who helped select the current set of prevention research centers." This article summarizes the IOM's vision for the program, as articulated in the report *Linking Research and Public Health Practice* (see citation on page 19.)

Six Characteristics of Future Prevention Research

The committee identified six characteristics that should define the prevention research centers in the future. Many of these characteristics had been realized by at least some of the prevention centers evaluated, and where this held true, the report suggested that these activities be expanded or strengthened.

"The degree to which the centers funded at the time of evaluation had achieved these characteristics was varied," said Randy H. Schwartz, MSPH, a member of the review committee. "The wide range was a function of the stages of development of the centers and how they were focused."

First. The committee recommended that the prevention research centers continue to focus on risk conditions and social determinants of health. The committee supports models of health in which the presence of good health, full functional capacity, and a positive sense of well-being—not merely the absence of disease—are outcomes of interest. The PRC Program was recognized for its role in encouraging communities to adopt broad models of good health status.

"The committee visited several centers, looked at documents, and talked about the program's history. We recognized the tremendous importance—and potential—of this program to public health practice," Mr. Schwartz said. "We saw the incredible value of this program to accelerating the diffusion of research to practice."

Second. The PRC Program was advised to sustain its orientation toward the community. The committee acknowledges that many entities not within the traditional domain of health both affect and have a stake in a community's health. Local governments, schools, and community organizations are among the partners with which the prevention research centers are encouraged to engage to translate research knowledge into community action. The committee applauds the breakdown of traditional boundaries so that true partnerships can be formed for research and dissemination projects jointly planned and produced with communities having joint ownership of the programs.

Third. The committee commented on public health as an interdisciplinary field incorporating epidemiology, biostatistics, social and behavioral sciences, administration, and environmental sciences. Health

"We saw the incredible value of this program to accelerating the diffusion of research to practice."

problems are recognized by the committee as complex and protracted. The committee recommended that the interdisciplinary approach to research continue to be used by the PRC Program in defining research problems and methodologies. The report states that "Interdisciplinary research is one of the defining features of *research centers* that distinguishes them from most academic departments and justifies their existence within a university."

Fourth. The committee further supported dissemination of research. The report suggests that the prevention research centers, in conjunction with state and local health agencies, enhance the process by which new prevention techniques reach communities. The committee believes that the prevention research centers can facilitate dissemination by incorporating research findings into teaching programs, publishing results in scholarly journals, sharing results with professionals in disciplines beyond public health (such as social work and pharmacy), and interpreting information for policymakers.

"The prevention centers need to be well integrated with mechanisms for improving practice, not just research. I endorse very deliberate linkages for forming a research agenda, having a summit about practice, and furthering discussion on dissemination research," Mr. Schwartz said. He added that ongoing, formal linkages with the health promotion and disease prevention directors in each state were highly desirable to create "more intentional synergy."

Fifth. The prevention research centers also were encouraged to enhance the interactive process for establishing research priorities that involves communities as equal partners in all phases of research projects. The committee proposes that the interactive model fits "logically and strategically with the legislative mandate of the PRC Program."

Alan W. Cross, MD, Director of the Center for Health Promotion and Disease Prevention, University of North Carolina at Chapel Hill, commented on this recommendation. "The Prevention Research Centers can lead the nation in developing research in partnership with people being 'studied,'" Dr. Cross said. "Doing so complicates research methods and relinquishes some control, but it links the research enterprise with the real issues affecting people and sheds light on the social determinants of health." Dr. Cross also commented on building community capacity to perpetuate change. "As the Prevention Research Centers demonstrate how this can be done," Dr. Cross said, "an example is set for gaining research results most useful to the public's health."

Sixth. The committee expressed the opinion that Congress inevitably establishes America's research priorities by how it allocates funds to research initiatives, institutes, and programs. The committee further noted that federal agencies often establish priorities independently of one another. According to the committee, the consequences of these circumstances are that 1) allocations are uneven, 2) important problems that fall between bureaucratic cracks may be neglected, and 3) problems may be attacked piecemeal. To reduce these consequences, the committee suggested interdisciplinarity in public health research to assess health issues in a comprehensive way. The committee believes that the PRC Program can be a leader in encouraging groups convened for this purpose.

The committee noted, however, that funding for the program has never been at the amount initially authorized. The committee found the level of funding at the time of the review not only inadequate, but also a critical barrier to the program's long-term success. "Despite the committee's recommendation—and

"The prevention centers need to be well integrated with mechanisms for improving practice, not just research."

even with the recent increases," Dr. Cross noted, "the now-current funding level remains short of the original intent. We wonder what we could achieve if this barrier were removed."

"We are grateful to the IOM committee for its thorough review and insightful recommendations," Ms. Riley said. "I believe the prevention research centers are positioned to take these and other recommendations into the future."

For further information, see *Linking Research and Public Health Practice: A Review of CDC's Program of Centers for Research and Demonstration of Health Promotion and Disease Prevention*. Washington, DC: National Academy Press, 1997.

The Case for Extramural Prevention Research

► *CONTINUED FROM PAGE 2*

When done well, prevention research yields a potent mix of public health practice and research competence. At the end of the next decade, we may look back and see that a shift in how we approach prevention research and its application evolved from programs such as the PRC Program. Nonetheless, even with our best efforts, we cannot know with certainty that the outcome of what we are doing will be entirely successful. But we *do* know that not doing these things will lead to failure in improving the health and well-being of all people who make up this nation.

Committee to Review the CDC Centers for Research and Demonstration of Health Promotion and Disease Prevention

Lawrence W. Green, DrPH (Chair), Director, Institute for Health Promotion Research; and Professor of Health Care and Epidemiology, University of British Columbia, Vancouver, British Columbia, Canada.

Noreen M. Clark, PhD, Dean and Marshall H. Becker Professor of Public Health, School of Public Health, University of Michigan, Ann Arbor, Michigan.

M. DesVignes-Kendrick, MD, MPH, Director of Health and Human Services, City of Houston Department of Health and Human Services, Houston, Texas.

John W. Farquhar, MD, Director, Stanford Center for Research in Disease Prevention; and Professor of Medicine, Health Research and Policy, Stanford University, Palo Alto, California.

Ira S. Moscovice, PhD, Professor and Associate Director, Institute for Health Services Research, School of Public Health, University of Minnesota, Minneapolis, Minnesota.

James O. Prochaska, PhD, Director, Cancer Prevention Research Center; and Professor of Psychology, University of Rhode Island, Kingston, Rhode Island.

Randy H. Schwartz, MSPH, Director, Division of Community and Family Health, Maine Bureau of Health, Maine Department of Human Services, Augusta, Maine.

Lee Sechrest, PhD, Professor, Department of Psychology, University of Arizona, Tucson, Arizona.

Harold C. Sox, Jr., MD, Chair, Department of Medicine; and Joseph M. Huber Professor of Medicine, Dartmouth Medical School, Lebanon, New Hampshire.

Kenneth E. Warner, PhD, Richard D. Remington Collegiate Professor of Public Health, School of Public Health, University of Michigan, Ann Arbor, Michigan.

Special Interest Projects Augment Core Efforts of PRCs

Core activities tied to the funding and mission of each prevention research center represent only part of the scope of the PRC Program. Since 1993, the prevention research centers have also been coordinating a growing number of special interest projects, called SIPs for short. Over the years, many of these projects have been funded by CDC and many by other agencies of the Department of Health and Human Services. The following list, by year of initial award, details currently active SIPs only.

1998

Effects of a Health Club Benefit for Medicare HMO Plans
- University of Washington

1997

Preventing Teen Pregnancy: Sharing Lessons Learned
- University of South Carolina

Coordinating Prevention Center to Build an Oral Health Network
- University of Alabama at Birmingham

Analysis of Existing Oral Health Data Related to Local Communities
- University of Illinois at Chicago
- The Johns Hopkins University
- University of North Carolina at Chapel Hill

Women's Cardiovascular Health Network
- University of Alabama at Birmingham
- University of California at Berkeley
- Columbia University
- University of Illinois at Chicago
- The Johns Hopkins University
- University of New Mexico
- University of North Carolina at Chapel Hill
- Saint Louis University
- University of South Carolina

Coordinating Center for Women's Cardiovascular Health Network
- West Virginia University

Coordinating Center for Tobacco Control Network
- University of Illinois at Chicago

Youth Response to Tobacco Control Policies
- University of Alabama at Birmingham
- Columbia University
- University of Illinois at Chicago
- The Johns Hopkins University
- University of Minnesota
- University of New Mexico
- University of North Carolina at Chapel Hill
- University of Oklahoma
- Saint Louis University
- University of South Carolina
- University of Texas Health Science Center at Houston
- University of Washington
- West Virginia University

1996

Evaluation of HIV Prevention Initiative 305
- Saint Louis University

Tobacco Prevention Communication Strategies for Youths
- University of Alabama at Birmingham
- Columbia University
- University of Illinois at Chicago
- The Johns Hopkins University
- University of New Mexico
- University of North Carolina at Chapel Hill
- University of Oklahoma
- Saint Louis University
- University of South Carolina
- University of Texas Health Science Center at Houston
- University of Washington
- West Virginia University

1995

Screening for Colorectal Cancer: Development of Standards for Quality of Sigmoidoscopy
University of North Carolina at Chapel Hill

Reducing Cardiovascular Risk Among Black Women Aged 40 Years or Older
The Johns Hopkins University

Peer Support Intervention for Cardiovascular Risk Among African American Women Aged 40 Years or Older
University of Alabama at Birmingham

Improving Osteoporosis Prevention Behaviors in Minority Women Aged 40 Years or Older
University of North Carolina at Chapel Hill

Assessment of Moderate Physical Activity Among Minority and Underserved Women Aged 40 Years or Older
University of South Carolina
University of Texas Health Science Center at Houston

Environmental and Policy Interventions to Increase Physical Activity Among Minority Women Aged 40–75 Years
Saint Louis University

Improving the Delivery of Diabetes Care to Women in Minority Groups
University of North Carolina at Chapel Hill
University of Washington

Attitudes Toward Hysterectomy, Oophorectomy, and Surgical Menopause Among Minority Women
University of Alabama at Birmingham
University of New Mexico
University of South Carolina
University of Texas Health Science Center at Houston

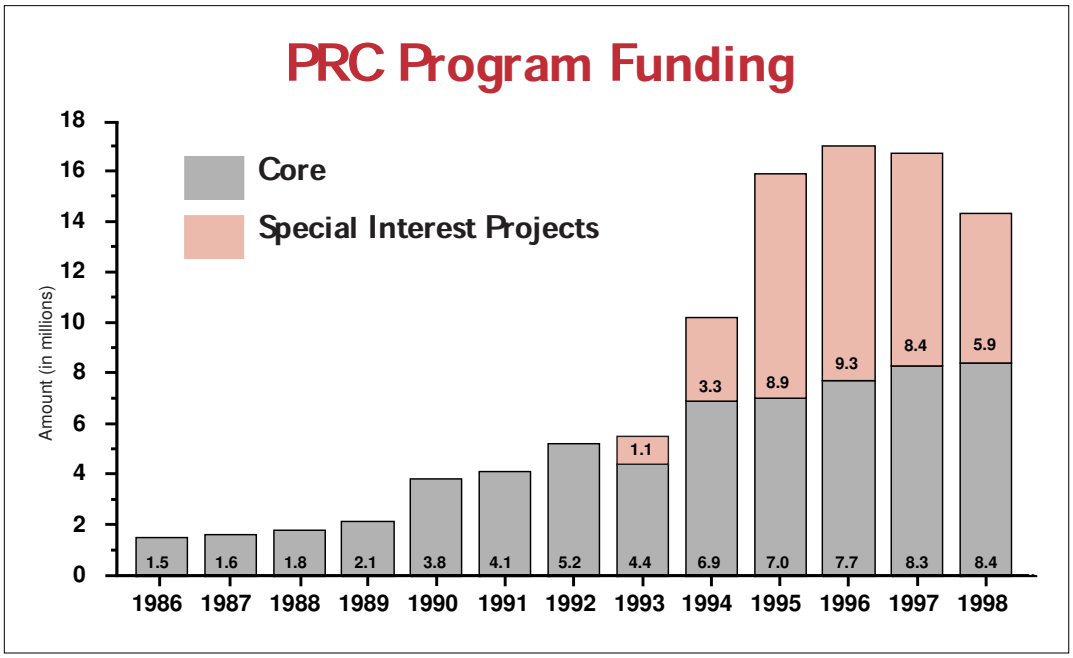
1994

Physical Activity Training for Public Health Professionals
University of South Carolina

1993

Tobacco Training Center for State Health Departments
University of North Carolina at Chapel Hill

Maternal Morbidity
University of North Carolina at Chapel Hill



Unique Partnerships for Women's Health

In 1991, when the National Institutes of Health (NIH) launched the Women's Health Initiative (WHI), the agency sought a partner for the part of the study concerning community prevention, and CDC's PRC Program emerged as a good match. Several prevention research centers had already been operating for up to five years and had demonstrated effectiveness in forming community relationships that could help promote health initiatives.

"At NIH, we saw that we could develop an effective partnership with another agency—and its partners—that had similar goals in primary prevention," said Loretta P. Finnegan, MD, Director of Community Prevention and Outreach for the WHI. "By sharing our expertise and resources, we can not only advance the research agenda in women's health but demonstrate a model of cooperation that other agencies may want to follow."

Overview of the WHI

The WHI is a three-component project designed to address aspects of women's health that have been neglected in biomedical research. A randomized clinical trial of 67,500 postmenopausal women is examining the health effects of hormone replacement therapy, dietary modification, and calcium and vitamin D supplementation. An observational study is tracking the medical history and health habits of about 100,000 women aged 50–79 years. A community prevention study is conducting and evaluating prevention strategies that encourage women of all races and socioeconomic backgrounds to adopt healthful behaviors. The goal of the community prevention study is to create model programs that can be implemented in a wide range of communities throughout the nation. Seven prevention research centers are responsible for this component.

The National Institutes of Health's Loretta P. Finnegan, MD, has been a catalyst for interagency cooperation in research that can advance women's health.

Women of all backgrounds, all over the nation, were ready and willing to share in the research and improve their health.

Results From the Prevention Research Centers

Dr. Finnegan is exuberant about the results she observed during site visits to several centers. "Creative researchers at the various institutions are using an array of methods, including focus groups, pretest interviews, community training, piloting of survey instruments, soliciting participation for intervention and control groups, conducting surveys, and offering health screenings and assessments. Simultaneously, the researchers are evaluating procedures and dissemination mechanisms for sharing the information gained through these activities."

Dr. Finnegan was equally impressed—and touched—by how ready and willing women of all backgrounds, all over the nation, were to share in the research and improve their health. Dr. Finnegan recalled some of her experiences: "During site visits to four prevention research centers, we met with African American, Hispanic, and American Indian women who were eager to express their thoughts about hysterectomy and surgical menopause. In Baltimore, we not only observed church-based projects designed by The Johns Hopkins University,

but we joined participants in enjoying a healthy meal and exercise. In the little community of Uniontown, Alabama, where the University of Alabama at Birmingham is conducting studies, we heard testimonials from women about lifestyle changes they have made, thanks to a commitment to health advocated by local community health advisors. These are only a few examples," Dr. Finnegan added.

(Editor's note: For more information about the Baltimore and Uniontown programs, see *cdnr*, Fall 1997, pp. 22–24. Also, the Uniontown project was profiled in the Women's Health section of *The New York Times*, June 21, 1998, p. 24.)

Dr. Finnegan particularly endorses projects to assess and enhance physical activity, known to affect cardiovascular disease, osteoporosis, and diabetes—three conditions most prevalent in the targeted group of women. She is also supportive of the prevention research centers' efforts in women's reproductive health. "Women have had a long history of not being appropriately informed about reasons for hysterectomy and surgical menopause," Dr. Finnegan said. "It is most important that we learn from women about their attitudes and knowledge concerning these procedures. Then we can develop teaching tools to permit women to be well informed and able to discuss options with their physicians." Much of the prevention research centers' activities in this area falls within a project of the WHI titled "Understanding Ethnic Variations in Women's Attitudes Toward Hysterectomy and Menopause."

Future Challenges

In looking to the future, Dr. Finnegan cites several challenges. "Continued funding is always a challenge. I hope that the community prevention study will remain a priority, particularly now that we are receiving results that show us possibilities." Dr. Finnegan added that how to reach women of racial and ethnic minority groups will also remain a challenge. "Health professionals will have to address a host of issues for women, including how to personalize interventions; how to overcome barriers of language, literacy, and transportation; how to respect diverse food preferences; how to overcome reluctance to attend activities outside the home; and how to fulfill obligations to other people that might otherwise interfere with taking care of themselves."

But Dr. Finnegan is hopeful about the future. She cites the PRC Program as a mechanism for encouraging widespread acceptance of preventive practices and adapting research to communities at particularly high risk. According to Dr. Finnegan, both these accomplishments are consistent with the public health agenda important to both NIH and CDC. In fact, Dr. Finnegan emphasizes this importance. "Epidemiologists and clinical researchers define major health concerns, preventive measures, and treatments. If we can't apply these discoveries to people throughout our communities—especially those at greatest risk—then we have failed. Then the research is of academic interest only and not to improve the health of our nation."

"If we can't apply these discoveries to people throughout our communities—especially those at greatest risk—then we have failed. Then the research is of academic interest only and not to improve the health of our nation."

For further information about the WHI projects, contact Loretta P. Finnegan, MD, Director, Community Prevention Study, Women's Health Initiative, and Medical Advisor, Office of Research on Women's Health, National Institutes of Health, Building 1, Room 201, 9000 Rockville Pike, Bethesda, MD 20892; 301/402-1770.

Education

Pharmacy Students Gain CDC Experience Through Clinical Rotations

Beginning in May 1999, Doctor of Pharmacy candidates at the Mercer University Southern School of Pharmacy can include CDC experience in the clinical rotations required during their fourth year. An affiliation agreement between CDC and the university will allow students to be involved in broad-ranging chronic disease issues such as those in tobacco and health, reproductive health, drug therapy for diabetes and cancer, and nutrition. Besides rotations in the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), students can rotate through the Agency for Toxic Substances and Disease Registry, the National Immunization Program, and the National Center for Infectious Diseases. NCCDPHP took the lead for this activity and helped develop the syllabus for each rotation. For further information, contact Jim Dowdy, Public Health Advisor, Program Services Branch, Office of the Director, NCCDPHP, CDC, Mail Stop K–44, 4770 Buford Highway, NE, Atlanta, GA 30341-3717; 770/488-5062; E-mail jpd2@cdc.gov.

Communications

4th Annual Youth Media Contest to Counter Tobacco Advertising

CDC's Office on Smoking and Health (OSH) is sponsoring its fourth annual Youth Media Contest. Young people are encouraged to apply their creativity to this year's theme, "Tobacco—The Truth Unfiltered," and sort fact from fiction about tobacco use. Awards are slated for the best news story, feature article, editorial, editorial cartoon, television and radio public service announcements, Web site design, poster, essay, and educational video in both middle and high school divisions. First-place entries will be added to a national tobacco control Media Campaign Resource Center or promoted nationally on selected Web sites.

First-place winners will receive an award certificate, a $100 U.S. savings bond, a gift, and will be eligible for a grand prize drawing for a trip to New York City to meet cover model Christy Turlington and enjoy a VIP tour of MTV studios. Second- and third-place winners also will receive a certificate and gifts. The first 1,000 entrants will receive a free T-shirt. Entries will be judged by a panel of celebrities and professional journalists.

For more information or to request an entry package, visit the OSH Web site at http://www.cdc.gov/nccdphp/osh/youth/index.htm; send E-mail to tobaccoinfo@cdc.gov, or call 300/CDC-1311.

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Screen for Life—The National Colorectal Cancer Action Campaign

A new communications campaign now being launched aims to raise awareness of colorectal cancer, the second-leading cause of cancer-related deaths in the United States. CDC collaborated with the Health Care Financing Administration and the National Cancer Institute to develop "Screen for Life" to encourage screening for colorectal cancer among people aged 50 years or older. State health departments are encouraged to join in the effort. To find more information about the national campaign, visit the Web site http://www.cdc.gov/cancer/screenforlife, or contact the campaign manager, Brian Southwell, Communication and Behavioral Sciences Branch, Division of Cancer Prevention and Control, NCCDPHP, CDC, Mail Stop K–48, 4770 Buford Highway, NE, Atlanta, GA 30341-3717; 770/488-3250.

Oral Health and Cancer Care Campaign

CDC has joined with the National Institute of Dental and Craniofacial Research (NIDCR), the National Cancer Institute, the National Institute of Nursing Research, and the Friends of the NIDCR in an awareness campaign about oral health and cancer treatment. The campaign aims to inform oncology and oral health professionals about the oral complications of cancer treatment, to encourage communication between providers, and to help patients become active in their cancer care. Oral complications can become so severe that patients can tolerate only low-dose, less-effective anticancer drugs, may postpone or discontinue treatments, or may develop systemic infections. Materials for patients explain how to ensure oral health before and during treatment. Information for professionals provides guidance on preventing or managing oral complications. Contact the National Oral Health Information Clearinghouse, Attn: OCCT, 1 NOHIC Way, Bethesda, MD 20892-3500; toll-free telephone 877/216-1019; Web site http://www.aerie.com/nohicweb; E-mail nidr@aerie.com.

Information Sources

Youth Risk Behavior Data Now Available on CD-ROM

A multimedia CD-ROM, *Youth97*, provides easy access to data collected from 1990 to 1997 through the Youth Risk Behavior Survey. CDC's Division of Adolescent and School Health (DASH) now makes *Youth97* available free of charge for use on Windows 3.1, 95, 98, or NT computers.

Users of *Youth97* can examine youth risk behaviors in six categories (injury, tobacco use, alcohol and other drug use, sex, diet, and physical activity). National, state, and local data can be compared by gender, race or ethnicity, and grade. The program helps create trend graphs and tables and includes a video describing how state and local agencies use the data. For more information or to request copies, access the DASH Web site at http://www.cdc.gov/nccdphp/dash/yrbs or call 770/488-3257.

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Diabetes Information System Goes Live

A new public inquiry and publication requests system is now available for health professionals and laypersons seeking information on diabetes. The system, which is a service of CDC's Division of Diabetes Translation, is accessible in multiple ways: toll-free telephone 877/CDC-DIAB (877/232-3422), fax 301/562-1050, E-mail ccdinfo@cdc.gov, or mail P.O. Box 8728, Silver Spring, MD 20910. For further information about the system, contact Nancy Haynie-Mooney at 770/982-3761; E-mail nah5@cdc.gov.

New Home Reference on Children's Nutrition

William H. Dietz, MD, PhD, Director of CDC's Division of Nutrition and Physical Activity, and Loraine Stern, MD, Associate Clinical Professor, Department of Pediatrics, UCLA School of Medicine, have coauthored the *Guide to Your Child's Nutrition: Making Peace at the Table and Building Healthy Eating Habits for Life*. This guide gives information and strategies for parents of newborns through adolescents. The authors offer suggestions for getting children to eat the right foods and for dealing with negative influences, such as those from advertisements. Other topics include eating disorders, food allergies, special dietary needs, alternative diets, food supplements, food safety, and weight. The guide is published by the American Academy of Pediatrics. Further information about the book and ordering information are available on the association's Web site http://www.aap.org.

Conferences

Conference on Comprehensive Cancer Control Planned for September

To foster a comprehensive approach to cancer control, CDC's Division of Cancer Prevention and Control (DCPC) is coordinating with CDC colleagues and external partners to present "Meeting the Challenges of Comprehensive Cancer Control," September 8–10, 1999, at the Marriott Marquis, Atlanta, Georgia. The conference is designed to address the increasing scope and complexity of cancer prevention and control issues and to engage participants from various public, private, and voluntary health agencies and organizations in sharing experience, knowledge, and skills concerning cancer sites, risk factors, and behaviors. DCPC's collaborators include three CDC units (Office on Smoking and Health, Division of Oral Health, and Division of Adolescent and School Health) as well as the National Cancer Institute, the American Cancer Society, the Association of State and Territorial Chronic Disease Program Directors, and the Association of State and Territorial Directors of Health Promotion and Public Health Education. For more information, contact Beth Layson, DCPC, NCCDPHP, CDC, Mail Stop K–52, 4770 Buford Highway, NE, Atlanta, GA 30341-3717; 770/488-4226.

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Annual Diabetes Conference this Spring

CDC's Divison of Diabetes Translation holds its 1999 Diabetes Translation Conference in Albuquerque, New Mexico, April 26–29, 1999. For conference announcements, access the Web site http://www.cdc.gov/diabetes. For more information, contact Norma Loner at 770/488-5376; E-mail nbl1@cdc.gov.

National Leadership Conference on HIV/AIDS Education Slated for August

The National Leadership Conference to Strengthen HIV/AIDS Education and Coordinated School Health Programs will be held at the Marriott Marquis in Atlanta, Georgia, August 26–27, 1999, in conjunction with the National HIV Prevention Conference, which runs from August 29 to September 1, 1999, at the Atlanta Hilton and Towers. The conference, which is cosponsored by CDC's Division of Adolescent and School Health and the U.S. Department of Education, promotes collaboration between health and education leaders, provides up-to-date information about resources, and offers technical assistance and training. For further information, contact Judy Powers at 770/488-3167.

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NCCDPHP Internet Web site:
http://www.cdc.gov/nccdphp/nccdhome.htm

NCCDPHP's Deputy Director Selected for CDC Post

Virginia S. Bales, MPH, has accepted the position of Deputy Director for Program Management (DPPM), CDC. In this position, she will provide leadership for the development of program strategies and systems to enhance CDC's mission and public health goals. The DPPM ensures that CDC has state-of-the-art facilities, information systems, equipment, and efficient, effective strategies and mechanisms for external funding. Ms. Bales will also provide leadership for the formulation and execution of the annual budget.

Ms. Bales has been Deputy Director of NCCDPHP since the formation of the center in 1988. During this time, she provided outstanding leadership and contributed greatly to the growth of the center and to the field of chronic disease prevention and health promotion as a whole. Ms. Bales joined CDC in 1970 and progressed through a wide range of positions. In 1995, she was awarded the Presidential Distinguished Executive Rank Award for an exceptional career with the Public Health Service, and in 1998 she received the Roger W. Jones Award for Executive Leadership.

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