

## Hispanic Oncologist Becomes a Media Star With TV-Radio Health Messages

by Neil Swan, Staff Writer    Photos by Bill Branson

Dr. Elmer E. Huerta is a respected physician now concentrating on cancer prevention efforts. He's also a radio and TV media "star" and a celebrity who is sometimes spotted and mobbed by his fans at D.C. United pro soccer games or other gatherings popular with Latinos.

As host of "Cuidando su Salud" (Taking Care of Your Health), the 51-year-old oncologist presides over the only national syndicated daily Hispanic radio program on health. His one-minute reports on virtually every area of health and medicine are broadcast by 100 Spanish-language radio stations nation-wide.

In Washington, Huerta is widely known for the popular daily 1-hour radio program "Consultorio Comunitario" (The Community Clinic of the Air), answering listeners' phone-in questions on health. He is known in Spanish-speaking communities across the nation for the weekly one-hour program "Hablemos de Salud" (Let's Talk About Health), which is broadcast every Saturday on satellite Dish Network Channel 9407.

Huerta is director and founder of the Cancer Preventorium at the Washington Cancer Institute of the Washington Hospital Center. Born in Peru, where he obtained his medical degree, he completed a fellowship in cancer research at



With patient at cancer screening center

the Johns Hopkins Oncology Center and a fellowship in cancer prevention at the National Cancer Institute (NCI). He is principal



Dr. Huerta gestures while advising caller on his phone-in radio program

investigator for the Latin American Cancer Research Coalition, part of CRCHD's Special Populations Networks and a member of NCI's National Cancer Advisory Board.

Huerta is dedicated to health outreach and education, particularly to Latino groups, which are relatively linguistically isolated in the U.S. The best tool for reaching this audience is the broadcast media, which carry powerful cancer prevention and health promotion messages to hard-to-reach Latino communities, Huerta says fervently.

In his native Peru "he saw the light" for pursuing media-based outreach to hard-to-reach groups when he performed triage for cancer patients in an outpatient clinic. There he saw first-hand the devastation of cancer on people who are poorly educated, who lack access to medical advice, and have a "fatalistic" attitude toward cancer, he explains. Often, in fear or ignorance, people "waited too long" to seek medical aid, he says.

"I thought to myself: These people are so knowledgeable about their novelas (soap operas) and sports and entertainment programs, yet they know so little about basic health matters. I

asked: Can we use radio and TV to sell health like the tobacco companies use the media to sell cigarettes?”

Thus was born his commitment to broadcast-based health prevention and outreach. “It began as a hobby, turned into a passion and has evolved into a new health systems outreach paradigm,” he says.

On his daily radio broadcast, Huerta is entertaining as well as informative, peppering his program with tango music, or other “culturally appropriate” music, and, sometimes his readings of Spanish-language poetry. Broadcasting from his office in the Washington Cancer Institute, just off a

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**“It began as a hobby,  
turned into a passion....” — Dr. Huerta**

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busy patient waiting room, Huerta laughs and jokes with his audience, selects music from a sagging shelf of CDs, and then bobs rhythmically with the music selections, “just like a DJ,” he jokes, a public health DJ.

He takes calls from radio listeners, about 65% of them women, but avoids giving medical advice. “I tell them I can’t diagnose over the air. If they have a medical problem, I tell them they must go to a physician for an examination and diagnosis.”

He urges one woman caller to “be assertive” in asking questions of her doctor when she does not understand her diagnosis or drug treatment schedule. The woman, who had called the previous week, dutifully went to a doctor on Huerta’s advice, and then called back, as he had asked her to do. “Her doctor wrote several things on a paper, things that she does not understand, and gave her several prescriptions. But he gave her no advice and scheduled no follow-up visits. That’s why I told her and the listeners to *be assertive*, ask questions when you don’t understand, don’t let the doctor just give you some medicine and dismiss you,” Huerta says.

On his radio and TV programs, Huerta speaks “broadcast Spanish,” free of slang or idioms. He gives vivid explanations of medical concepts and conditions, trying to keep his

descriptions understandable to anyone with a sixth-grade education. On the live TV show, he uses multi-media slide presentations that he develops himself on his laptop computer.

As a result, Huerta is widely recognized, respected, and influential among Latinos. After his national radio reports began to promote the NCI Cancer Information Service’s toll-free phone number (1-800-4-CANCER) the number of Spanish-speaking callers increased 700%. He is often recognized in Latino communities and restaurants, and besieged by friendly fans, many of whom say he is “like a trusted friend.”

Huerta is the president and founder of Prevencción, Inc., a not-for-profit company dedicated to the production and dissemination of educational materials for the Latino community in the U.S. Prevencción maintains a web site at: [www.prevenccion.org](http://www.prevenccion.org)

His prevention efforts are based on his ardent belief that the nation’s medical system should be reformed from being primarily a *treatment* system to one more focused on the early detection and treatment of early-disease cases, particularly cancer. “The best cure for cancer is prevention and early detection,” he says.

In 1994, Huerta started Washington Hospital Center’s Cancer Risk Assessment and Screening Center. The facility is dedicated to screening younger, symptom-free people, particularly those with no health insurance, *before* they become ill. About 95% of the patients screened at the Center, paying a \$64 fee, are Hispanic and nearly all of them listen to his radio program. About 85% are asymptomatic, which the doctor says means that they are listening to his prevention messages.

Since 1989, his successful efforts to develop ethnically sensitive, media-based community outreach messages have followed four basic principles:

- Use the media *consistently*
- Develop *comprehensive* health education programs
- Use all media channels available for the community
- Develop a *trusted messenger*. ↻

# Researchers' "Pioneering" Efforts to Ease Cancer Health Disparities Are Praised by NCI Director at SPN 2003 Summit Conference

by Neil Swan, Staff Writer

The researchers of the 18 field research projects comprising the Center's Special Populations Networks (SPN) have been praised for their "pioneering" efforts to deliver research advances to the nation's minorities and underserved communities.

The National Cancer Institute's goal of eliminating death and suffering due to cancer by the year 2015 through a coordinated process of *discovery, development, and delivery* is moving forward, but it requires the continued commitment of researchers in the field to achieve the critical delivery of research advances, NCI Director Dr. Andrew C. von Eschenbach told the group of cancer researchers.

"We need your help" in the delivery phase of the burden-elimination process because "you are the pioneers" in outreach efforts to reduce cancer health disparities, von Eschenbach said in addressing researchers at the NCI's Special Populations Networks Cancer Health Disparities Summit 2003 held in July in Washington, D.C.

More than 300 investigators and staffers from the SPNs' research coalitions reported on their progress and shared their outreach advances and insights at the Summit. The SPN is funded and managed by the CRCHD.

The sessions spotlighted how the various SPN research projects are functioning as community-based cancer control partnerships, now actively engaging their communities in a range of pilot research activities and moving forward to become peer-reviewed and funded cancer control and cancer prevention research and demonstration projects.

The SPN, with projects in 15 states, seeks to build relationships between large research institutions and community-based

programs and to find ways of addressing critical questions about the burden of cancer in minority communities. NCI research grants are issued to researchers for public health projects that may focus on many communities nationwide or, perhaps, more focused projects in a single county, tribal nation, or specific population subgroup.

Von Eschenbach said the NCI is seeking to address the problem of cancer health disparities by "partnering and leveraging" with other NIH Institutes, other HHS agencies, and the non-profit

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**"[The SPN is] part of one of the most successful minority/underserved programs in NCI history."**  
— Dr. Kenneth Chu

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and for-profit sectors.

The SPN is already achieving important funds-leveraging successes, said Dr. Kenneth Chu, CRCHD Program Director, in a status report he delivered at the 3-day Summit. He said the SPN research projects have already leveraged their activities to receive some \$20.5 million in funding from non-NCI sources. "That represents about one-half of the money that NCI granted you to start your projects," Chu told the SPN staffers. (See STAT BITE, Page 7.) "In my opinion, you are a part of one of the most successful minority/underserved programs in NCI history."

In April 2003, the SPN transitioned to the third and final phase (years 4 and 5) of its 5-year projects. In Phase III the various SPN programs will be devoted to utilizing information gleaned from their pilot projects to develop full-fledged investigator-initiated research grant applications, as well as to enhance the infrastructure developed in the earlier phases. ♡

## Careful Planning Guides Center's Strategies To End Disparities by 2015

Meeting CRCHD's mission, to *Reduce the Unequal Burden of Cancer*, is challenging. It requires comprehensive studies of the issues; planning, testing and evaluating research; and designing ways to more quickly bring the fruits of this research to relieve the unequal burden of cancer disparities to the racial and ethnic groups where it exists today. It requires careful analysis and insightful *planning* for both short- and long-term strategies.

"Planning is crucial to the CRCHD so that we more quickly bring the fruits of this research to all Americans, irrespective of their race, culture, or economic status," says Dr. Harold P. Freeman, director of CRCHD. "Foresight will help us find and promote ways to more quickly correct conditions that force a heavier burden of disease on some groups of Americans, particularly the poor and the underserved."

The strategic planning involves activities at three management levels – the National Cancer Institute (NCI), the National Institutes of Health (NIH), and the U.S. Department of Health and Human Services (HHS).

There are four broad-ranging planning and strategic management initiatives that are guiding CRCHD's agenda. They are (1) the National Cancer Institute director's vision foresees elimination of death and suffering from cancer by the Year 2015, (2) a broad-ranging Cancer Health Disparities Progress Review Group (PRG) to analyze social and medical issues and to identify new opportunities for Government health agencies to develop, test, and promote strategies to eliminate disparities among racial and ethnic groups, (3) the NIH Roadmap for Medical Research, designed to accelerate medical research. Let's look at the three planning and strategic design efforts, and (4) the NIH Strategic Plan.

The NIH Roadmap, designed to speed

medical research and the delivery of its fruits to the patients who need them, was announced in September by NIH director Dr. Elias A. Zerhouni as a series of far-reaching initiatives. Despite remarkable recent advances against many diseases, "very real – and very urgent – needs remain," he says. "NIH is now drawing all fields of science together in a concerted effort to meet these challenges head-on."

The NIH Roadmap has three major themes: New Pathways to Discovery, Research Teams of the Future, and Re-engineering the Clinical Research Enterprise.

"The Roadmap initiative addressing the Re-engineering of the Clinical Research Enterprise is especially relevant for health disparities research," says NIH deputy director Dr. Raynard S. Kington.

"There will be special attention to

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**"...unprecedented opportunities to link providers who serve disparities populations into the research enterprise."**

**– Dr. Raynard S. Kington**

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recruiting individuals from diverse backgrounds, including women and underrepresented ethnic and minority groups, for professional training as future leaders in clinical research, for participation as research practitioners in the National Clinical Research Corps, and for balanced and representative inclusion as study populations in Clinical Research Networks," he says. "The formation of the National Clinical Research Corps and a national network of clinical networks will present unprecedented opportunities to link providers who serve disparities populations into the research enterprise."

Dr. von Eschenbach says, "I believe we are at what I call a strategic inflection in biology which means we're at a point of unprecedented

growth in three key areas related to cancer research: knowledge, technology and resources.

“The goal of eliminating suffering and death due to cancer provides this focus,” he continues. “It does not mean ‘curing’ cancer but, rather, it means that we will eliminate many cancers and control the others, so that people can live with – not die from – cancer. We can do this by 2015, but we must reach for it. We owe it to cancer patients around the world – and their families – to meeting this challenge.”

“We’ve been able to understand that cancer is a disease process,” he says. NCI will focus its efforts and accelerate its progress with what he calls the “seamless three-D approach” to cancer research – the three Ds being discovery, development, and delivery.

He explains that meeting NCI’s challenge goal by 2015 involves developing new initiatives and priorities in seven key areas: molecular

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### **The 2015 challenge goal involves developing new initiatives and priorities in seven key areas.**

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epidemiology, integrated cancer biology, strategic development of cancer interventions, early detection, prevention and prediction and integrated clinical trials system, overcoming health disparities, and bioinformatics.

He notes that medically underserved populations suffer from a disconnect between discovery and delivery that may contribute to health disparities along racial or ethnic lines.

Shorter range, within more traditional management structure and goals, is the Trans-HHS Cancer Health Disparities **Progress Review Group** (PRG). While the other strategic planning initiatives are broader and more long-term, the PRG planning is more focused, and, for the first time in NCI history, is not restricted to focusing on cancer of a single body organ. And it is

being conducted within the framework of all the agencies and activities of the entire Department of Health and Human Services, not just NCI or the National Institutes of health.

The purpose of the PRG is to facilitate a coordinated and comprehensive analysis to identify new opportunities for HHS agencies to address cancer health disparities, implement new initiatives, and evaluate their progress. The PRG reports and preliminary recommendations are due early next year and will serve as a demonstration project to test approaches used to review and evaluate progress against health disparities related to other diseases as well.

The PRG approach has been used effectively in the past by the NCI to develop national agendas for disease-specific research and promises to be equally valuable for evaluating the activities designed to eliminate cancer health disparities. The PRG involves representatives from agencies throughout HHS – from the Indian Health Service, and the Veterans Administration to the NCI – in demonstrating a process for targeting cancer disparities that could be applied to identifying and examining disparities related to other diseases.

All four of these different planning mechanisms are independent but integrated efforts to best develop and utilize the vast resources of the NIH and the NCI, in which some 5,000 lead scientists are involved in research and 10,000 physicians and two million patients participate in NCI-sponsored clinical trials for cancer treatment, prevention, and early detection interventions.

For more information on the NIH Roadmap, go to <http://nihroadmap.nih.gov>

For more about von Eschenbach’s challenge goal for the Year 2015, go to <http://www.nci.nih.gov/directorscorner/directorsupdate-08-27-2003> ↗

## Patient Navigator to Help Eliminate Cancer Suffering and Death by 2015

by Neil Swan, Staff Writer Photo: Bill Branson

There is a devastating emotional response when someone is first diagnosed with cancer. The patient is confronted with an array of uncertainties that may or may not provide motivation to proceed immediately with appropriate treatment. Evidence shows that in addition to unequal access to health care, racial/ethnic minorities and underserved populations do not always receive timely, appropriate advice and care when confronted with a cancer diagnosis.

The Patient Navigator Program is designed to assist the underserved with cancer-related abnormal medical findings in navigating the cancer care system, thereby helping patients to close the gap between detection and appropriate treatment delivery. With Patient Navigator assistance, a patient would receive more timely diagnosis, more timely treatment, more information and education relating to treatment and cancer-preventive lifestyle behaviors, and more satisfaction with the health care system experience.

A Patient Navigator is an experienced advocate from the patient's community – often a lay person, social worker, or nurse – who functions as a guide to help cancer patients and their families. At diagnosis, the Navigator relays accurate and timely information to the patient and family regarding the patient's specific diagnosis. With knowledge of the health care system, the Navigator is **credible** and able to communicate with the patient the procedures.

The Navigator is a reliable ally to lean on for advice, support, and direction, who understands the patient's fears and hopes, and alleviates barriers to effective care by coordinating services -- thus increasing the cancer patient's chances for survival and quality of life.

The Navigator may place the new patient in contact with survivors of similar cancer diagnoses and with cancer patient support groups that may offer comfort, support and understanding, and also

chart a course that permits the patient to surmount barriers, such as:

- financial barriers, especially for the uninsured or underinsured
- communication and information barriers, particularly for patients with reading or learning problems and those who speak little English
- medical system barriers, such as misplaced or missing medical test results
- physical barriers, such as traveling to sometimes distant clinics and doctors, missed appointments,
- emotional barriers, which lead some patients to break or postpone doctor appointments, procrastinating because they fear they will learn "the worst."

As the underserved community perceives that timely response to an abnormal finding is possible and more easily attainable, community participation in cancer screening activities should increase. Thus, the Patient Navigator Program should have an impact on reducing cancer disparities and reducing the burden of cancer.

The National Cancer Institute has awarded funding to two hospitals to establish and monitor

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**"When I assist cancer patients, financial assistance is their number one priority."  
— Grisel Mejia**

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Patient Navigator Programs as part of its Cancer Disparities Research Partnerships (CDRP): Rapid City Regional Hospital in Rapid City, South Dakota and Laredo Medical Center in Laredo, Texas. The Center to Reduce Cancer Health Disparities (CRCHD) supplements funds to the Patient Navigator Program at both institutions.

The Rapid City Regional Hospital serves 100,000 Native Americans from surrounding communities and reservations. Laredo Medical Center serves a community that is 95% Hispanic with a high poverty rate. It serves about 50 colonias, or unincorporated subdivisions with living conditions similar to those in third world countries.

“When I assist cancer patients, financial assistance is their number one priority,” said Grisel Mejia, Patient Navigator at Laredo Medical Center. “If they have no health insurance, they ask, ‘How am I going to pay for this treatment?’ I complete an initial psycho-social assessment, review their financial status, and refer them to our Financial Services Department. We monitor their status and help them fill out the necessary forms.”

The next major issue for patients is coordination of transportation to the hospital for their appointments, said Mejia. The Navigator may arrange basic transportation or an ambulance or wheelchair van in order to deliver the patient to the hospital for his treatment.

After confirming the patient has access to the hospital, obtaining prescription drugs becomes a focus for the Navigator. “If there is no insurance coverage for drugs, in some cases I can contact the pharmaceutical company to apply for free or reduced-cost drugs,” she said. “I do the paperwork for the drug manufacturers who have special programs for the medically needy. It can take four to six weeks to gain approval and get the drugs.”

In addition to Rapid City and Laredo, CRCHD currently supports Patient Navigator pilot programs at select hospitals serving minority populations in the Northwest, where cancer is the third leading cause of death for Native Americans and Alaska Natives of all ages and the second leading cause of death for Native Americans over

the age of 45. CRCHD supports pilot programs at three sites of the Indian Health Service in the Portland area: Puyallup Tribal health Authority, Native American Rehabilitation Associates (NARA), and Yakama Indian Health Center. Puyallup is a reservation in suburban Washington. Yakama is in rural Washington, while NARA is in urban Portland, Oregon serving urban Native Americans and Alaska Natives.

Evaluations of the Patient Navigator programs in Laredo, Rapid City, and at the three Indian Health Service sites will help steer further developments and expansion of the Navigator concept. ↻

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## Health Care and the Plight of Poverty on Rural White Americans

*By Francis X. Mahaney, Jr. Staff Writer*

*Photo by Ernie Branson*

**“I despise you because you are dirty and filthy, but I love because you’re home, Tobacco Road.”**  
— *Edgar Winter and the band, White Trash*

Along a dusty road in southern Alabama where a dilapidated house trailer faces a windswept and croplless field lives Theresa, an impoverished white woman of southern heritage and her two young children. Looking older than her 36 years, Theresa lives without heat, without running water and a lump painfully growing in her breast but without the finances or the motivation to see a doctor. Living on \$169 a month, she naturally hasn’t seen a dentist in years and her front bottom teeth are starting to dropout, her gums diseased and too weak after smoking several packs of cigarettes a day. She won’t be expecting any more money from her husband -- he’s in prison.

Theresa is just one of millions of forgotten and impoverished white Americans that Auburn University Professor and Historian Dr. J. Wayne Flynt knows all too well. Flynt himself was born poor in Pontotoc, Mississippi, the grandson of a share cropper, later growing up in Anniston,



Patient Navigator Grisel Mejia, right, counsels a newly-diagnosed cancer patient at Laredo Medical Center in Texas — Photo: Laredo Medical Center

Alabama, the heartland of what the 1970's Rock Group "Edgar Winter and the White Trash," referred to as "Tobacco Road."

For several years, Flynt has become a crusader for poor white America, having written 10 books, three of which deal with poverty, two of which have been nominated for the Pulitzer Prize, including "Dixie's Forgotten People: The South's Poor Whites, (1979), "Southern Poor Whites," (1981) and "Poor but Proud: Alabama's Poor Whites" (1989). Having served on the American Cancer Society for the Socioeconomically Disadvantaged, Flynt is the founder of the Alabama Poverty Project and Sowing Seeds of Hope, a 30-year initiative to overcome poverty in Perry County, Alabama.

Flynt was recently introduced to the NIH Community by Dr. Harold Freeman, of the National Cancer Institute's Center to Reduce Cancer Health Disparities (CRCHD) at the NIH Clinical Center's Masur Auditorium. Freeman himself is a national authority on the health of the disadvantaged poor.

The Flynt lecture, "Poor Whites and Health" was the second in a series of lectures sponsored by CRCHD to explore issues relating to health disparities and the unequal burden of disease in American Society. The CRCHD was designed to study the causes of cancer disparities and recommend strategies and actions that will integrate proven cancer-related interventions and research advances into cancer treatment delivery for all Americans.

Flynt told the crowded auditorium while "there is no place in America where its good to be indigent, one could make a case that the best places to be poor are large cities because they generally have teaching hospitals that treat needy patients." Large American cities have public transportation that enables people to reach doctors and hospitals. Moreover, there is access to food stamp offices, free food pantries, local charities and local government assistance.

But an "equally compelling case" could be made that "rural areas are the worst places to be poor," Flynt said. While rural areas may have a stronger sense of community, identity, and kinship, there are fewer hospitals, clinics, physicians, public assistance agencies, charitable facilities, or forms of public transportation, he said.

Of the America's 100 poorest counties, 84 are in the south where child poverty rates are as high as 65%, Flynt noted. Alabama, Arkansas, Georgia, Kentucky, Mississippi, New Mexico, Oklahoma, South Carolina, Texas, and West Virginia have the highest poverty rates he said. Additionally, by 1970 3.9 million people of southern origin lived in Illinois, Indiana, Michigan, Ohio, and Wisconsin where white migrants outnumbered blacks 2 to 1. Another 2.5

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**"There is no place in America where its good to be indigent."  
— Dr. J. Wayne Flynt**

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million southern-born people lived in California where whites outnumber blacks 3 to 1. By the early 1980's approximately one-third of the 6 million Appalachian transplants living in the Midwest lived in extreme poverty, Flynt said.

Compounding these problems are unique cultural and sociological patterns said Flynt.

- Appalachian whites live in states that have historically produced most of America's tobacco products. Statistically, poor whites are much more likely to use tobacco products than more affluent whites.
- States in which poor whites mainly live have been reluctant to use tax policy as a deterrent to smoking. Deep South states have the lowest tobacco taxes in the country.
- Appalachian religion contains strong components of Calvinism and Fatalism. According to Flynt, desperately poor



maintain an unwavering belief in herb doctors, midwives, home remedies and religious faith like divine healing to provide what “inaccessible modern medicine can not.” One study in Roan Mountain, Tennessee revealed that 68 percent of the all white inhabitants believed the devil made people sick; 70 percent believed family members should be treated for worms; 33 percent still used folk remedies.

- Many poor whites lack health insurance. While a 1987 study found that 56 percent of women who had health insurance had a breast exam, only 34 percent of uninsured women did so.
- Dietarily both Southern poor whites and blacks tend to eat salted, cured and smoked foods high in saturated fats, contributing to the highest preventable early mortality rates in the nation.
- Inadequate housing is another confounding issue facing impoverished southern whites in America, said Flynt. "Non-urban southerners are three times more likely to inhabit substandard housing," said Flynt. In point of fact, 42 percent of the nation's rural families live in the south, with a staggering 83 percent showing evidence of rats, he said. Furthermore many rural areas such as Appalachia and the Mississippi Delta continue to lack basic amenities like running water.

A 1996 UC-Berkeley/Harvard study found that poor whites, motivated by racial pride and hostility toward other ethnic groups, are less likely to take advantage than their minority counterparts. Similarly lack of education has presented with a myriad of problems from unfulfilled special educational needs to long bus rides from coming from poor families with undereducated parents.

But maybe the greatest insult of them all has been the stereotyping of poor whites and southern

whites in general as "white trash," "brier hoppers," "red necks," "lintheads" and "hillbillies" with bad genes, bad English, lazy, stupid not to mention bad teeth, Flynt said.

The life of poor whites is so powerfully depicted in our culture, you only have to read John Steinbeck's *Grapes of Wrath*, or Erskine Caldwell's *Tobacco Road*, Jacquelyn Jones' *The Dispossessed*, and even tv reruns of the *Beverly Hillbillies*, Flynt said.

"It was precisely such stereotypes that paved the way for eugenics and the marginalization of blacks a century ago," Flynt said. "It was the basis for segregation and failed or inferior health care—remember the Tuskegee syphilis experiment. The intellectual assumptions of racial superiority shaped the policies of marginalization. The health care system has come a thousand miles since its 1920s and 1930s flirtation with racism and eugenics. My plea is that we grow in our understanding of and sympathy for the diseases and health problems that plague people of color, we must not substitute one set of victims for another," he concluded.

Flynt who is the recipient of a Woodrow Wilson fellowship and won 13 teaching awards at two universities, earned his Ph.D. in Southern Political history at Florida State University in 1962 and is presently a full professor on the history faculty at Auburn University. ♡



Professor and Historian Dr. J. Wayne Flynt

## **The National Institutes of Health (NIH) Seeks Public Comment on Strategic Research Plan and Budget**

The National Institutes of Health is posting the "NIH Strategic Research Plan and Budget to Reduce and Ultimately Eliminate Health Disparities, Fiscal Years 2002-2006", on the NCMHD website at <http://www.ncmhd.nih.gov> to invite public comment on the NIH health disparities research agenda. The NIH is seeking comments on its research plans for Fiscal Years 2004-2006.

"Despite tremendous medical advances and improved public health in America in recent decades, African Americans, Hispanics, American Indians, Alaska Natives, Asian and Pacific Islanders, and other medically underserved communities continue to suffer an unequal burden of illness, premature death and disability. In developing and updating the Strategic Plan to eradicate these health disparities, the NIH affirms its ongoing commitment to biomedical research discovery that will ensure improved health for all Americans," said NIH Director, Dr. Elias A. Zerhouni, M.D.

The Plan was developed by the NIH National Center on Minority Health and Health Disparities (NCMHD) in collaboration with the NIH Office of the Director, the other NIH Institutes and Centers, and the National Advisory Council on Minority Health and Health Disparities. The NCMHD leads, coordinates, supports and assesses the NIH effort to eliminate health disparities. The NCMHD supports and conducts basic, clinical, social sciences, and behavioral research; promotes research infrastructure and training; fosters emerging programs and the dissemination of health information; and reaches out to minority and other health disparities communities.

According to Dr. John Ruffin, Director, NCMHD, "The Strategic Plan defines a broad

framework for future efforts of research partners throughout the country to advance scientific knowledge that will improve diagnostic, treatment, and prevention strategies for reducing and eliminating the health disparities afflicting racial and ethnic minority populations and other health disparities populations across the Nation."

He further noted that "the genesis of health disparities is multi factorial and requires a coordinated interdisciplinary effort. The Strategic Plan reflects the ongoing commitment of a strong research alliance that is necessary to eliminate health disparities. At the heart of this coalition of NIH Institutes and Centers are our constituencies. Their input is essential to our success in identifying innovative and diverse approaches to eliminate health disparities."

The Strategic Plan has three main goals:

- RESEARCH – to investigate the development and progression of diseases and disabilities that cause disparities in health in minority and other populations.
- RESEARCH INFRASTRUCTURE – to increase minority health and health disparities research training, career development and institutional capacity.
- PUBLIC INFORMATION AND COMMUNITY OUTREACH – to ensure the public, healthcare professionals, and research communities are informed about the latest advances in health disparities research.

The "NIH Strategic Research Plan and Budget to Reduce and Ultimately Eliminate Health Disparities, Fiscal Years 2002- 2006" is currently posted on the NCMHD website at <http://www.ncmhd.nih.gov>. Written comments should be sent to the Strategic Plan Review Group, NCMHD, 6707 Democracy Blvd., Suite 800, Bethesda, MD 20892-5465 or may be transmitted electronically, via e-mail, to [NIHHealthDisparitiesPlan@mail.nih.gov](mailto:NIHHealthDisparitiesPlan@mail.nih.gov) and should include contact information, such as, name, organization, address,

and telephone and fax numbers.

The NCMHD is a component of the National Institutes of Health within the Department of Health and Human Services. ♡

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## Letters to the Editor

To the Editors of Equal Access:

My name is Freddie White-Johnson and I am the Project Manager of the Mississippi Deep South Network for Cancer Control. On the front cover of the Summer 2003-Volume 1 newsletter, I am that young lady (pictured) with the African American gentleman. I received a copy of the newsletter from one of my Alabama colleagues.



If feasible, would you please send us 100 copies to share with the staff, Mr. Anderson and his family, Dr. Lovetta Brown (a cancer survivor) and some of the volunteers?

The newsletter is very nice and I enjoyed reading it. Thanks for a wonderful story on the Mississippi Delta / Deep South. We are working really hard to educate the underserved about cancer and early detection. Without Deep South, many women would have fallen by the wayside (perhaps death). Because of the volunteers' efforts and support from providers, etc., so many underserved women have been identified and recruited for screenings (mammograms, pap test, pelvic examination and clinical breast examination). We (staff) have trained more than 400 women and men in the area of cancer education as well as provided them with leadership skills.

On behalf of the staff and especially the underserved women in Mississippi, I would like to say "THANKS".

Together, we can and will save lives!

Sincerely,

Freddie White-Johnson, Project Manager  
Deep South Network for Cancer Control ♡

## Stat Bite

### SPNs' Researchers Attract \$14.5 Million in Additional Funding

The Center's Special Populations Networks researchers are building on federal grants to chalk up funds-leveraging successes, according to Kenneth Chu, Ph.D., CRCHD Program Director, in a status report.

The 18 SPNs research projects have, in just 3 years:

- Leveraged grants to receive \$14.5 million in additional funding from non-NCI sources
- Conducted more than 1,000 cancer awareness activities
- Signed more than 300 partnerships with community-based organizations
- Trained more than 150 minority researchers
- Recruited more than 2,000 community-based lay volunteers for training in cancer awareness
- Submitted 196 grant applications for pilot projects (96 are already funded)
- Published in medical journals more than 110 research papers
- Created more than 20 SPN web sites and 20 cancer control newsletters ♡

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# Equal Access

Closing the Gap between Discovery and Delivery

Fall 2003 ♦ Volume 2

