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Introduction

Taking Stock of WISEWOMAN

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IN THE MID-1990s, CONGRESS BEGAN funding an innovative demonstration program to promote the health of underinsured and uninsured women aged 40–64. The program, known as Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN), builds on the longtime success of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Financially disadvantaged women who qualify for NBCCEDP services are also eligible to receive WISEWOMAN screening and lifestyle interventions, which aim to reduce their risk for heart disease, diabetes, and other chronic diseases. In demonstration projects across the country, women are given the tools and knowledge they need to become more physically active, adopt healthy eating habits, lead smoke-free lives, and address high blood pressure and high cholesterol.

After being launched in three states during an initial phase (1995–1998), the WISEWOMAN program has grown to include 14 ongoing projects. This special issue of the *Journal of Women's Health* highlights the broad aims and design of the WISEWOMAN program, showcases its early achievements, and takes stock of the challenges that must be addressed to ensure that the program lives up to its promise and makes a difference in women's health and lives.

The first set of papers[1–3] demonstrates that the WISEWOMAN program not only has reached economically disadvantaged women from a wide range of social, cultural, and geographic backgrounds but also has screened women who are at genuinely high risk of chronic diseases. For example, considering the 10 projects that were fully operational in 2002, nearly 3 of 4 women screened in almost all settings were either overweight or obese.[1] Such findings are striking.

Also intriguing are the details about racial and ethnic disparities observed by Finkelstein et al.[2] They found that WISEWOMAN participants' cardiovascular disease (CVD) risk factor profiles varied significantly by race and ethnicity at baseline. Finkelstein et al. make an important contribution to discussions of racial and ethnic disparities because they explain many of the disparities by controlling for individual characteristics, such as education, body mass index (BMI), and community characteristics derived from ZIP code and county data.

Mobley et al.[3] use spatial analysis techniques to consider a different type of disparity—spatial clustering of risk factors among WISEWOMAN participants in five states. In addition to finding evidence of clustering for two indicators of CVD risk (BMI and smoking behavior), Mobley et al. observe that the high-BMI clusters tend to be located in more socioeconomically disadvantaged neighborhoods. Taken together, these first three papers point to the importance of addressing disparities in risk and intervening to target the complex set of factors that give rise to disparities.

The report from the Massachusetts project shows that women who participated in the WISEWOMAN program had an average drop of 7%–9% in the prevalence of high blood pressure at 12-months follow-up.[4] In Arizona, women who attended the WISEWOMAN program had an average decrease of 6–11 mg/dl in total cholesterol after 12 months.[5] Whether these improvements in

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biological risk factors can be attributed to the program as a whole, to just one component, or to secular trends in risk factors cannot be determined because of the way these studies were designed. The studies were intended to compare the effects of more intensive lifestyle interventions with less intensive interventions. Although it appears that more intensive interventions improve biological risk factors by only a small amount over less intensive interventions,[4,5] the accumulated evidence on interventions reported in this supplement points to clear success in modifying nutrition and physical activity behaviors.[4–7] Using an impressively wide range of behavior change strategies (e.g., clinic-based counseling,[4–6] group education and activities,[4,5,7] community health worker support,[5] cultural tailoring[5–7]), WISEWOMAN projects have increased physical activity and improved nutrition across varied settings and populations. In North Carolina, the WISEWOMAN project went one step farther, conducting a follow-up intervention to promote ongoing adherence to new behavior patterns.[6] Using tailored health messages communicated by mail and in telephone counseling sessions, the maintenance intervention favorably modified participants' stage of change for physical activity but did not appreciably influence dietary and physical activity behaviors, perhaps because self-reported risk for both behaviors was already relatively low at the outset of the follow-up study.

Four papers in this special issue are especially relevant for practitioners and program managers wanting to launch WISEWOMAN or similar programs.[8–11] All four papers acknowledge the challenges of incorporating preventive health services into busy clinic settings. Parra-Medina et al.[8] present a seven-step process for redesigning existing educational materials to make them ethnically and culturally relevant and suitable for clinical practice. The process includes expert panel review of educational materials eligible for redesign. Notably, while considering 52 materials about diet or physical activity, panel members were more likely to highly rank materials perceived as "appropriate counseling tools for practitioners to use in practice settings."

Jilcott et al.[9] highlight the organizational factors that are likely to influence successful health counseling and examine the baseline assumptions of staff working in resource-constrained public health departments. After finding that many practitioners are skeptical of patients' willingness and ability to change health behaviors, Jilcott et al. conclude that carefully designed staff training is essential to promote more favorable provider attitudes, increase providers' confidence in their counseling skills, and strengthen their ability to counsel effectively.

Training is also discussed in an insightful paper by Sanders et al.,[10] who describe an intensive nutrition training course for community practitioners affiliated with WISEWOMAN or other health promotion programs. A key component of the course is a field practicum designed to enhance public health professionals' ability to conduct multilevel interventions that address family, community, organizational, and policy influences on dietary behavior. The authors note, however, that most frontline providers are focused on their interactions with individual clients and that training events must sell the idea "that individual behavior change is facilitated by an environment where it is easier to make the 'right' choices."

Mays et al.[11] provide a thorough and well-argued analysis of the opportunities and challenges of integrating preventive health services into community health center settings. The authors point out that the screening and lifestyle intervention services provided by WISEWOMAN will be effective in reducing the CVD burden only if women also have access to more comprehensive chronic care services. Traditionally, community health centers have excelled at providing core elements of chronic care management, such as treatment, case management, community outreach, and tracking of outcomes. Mays et al. offer a range of concrete suggestions designed to promote greater collaboration between the WISEWOMAN program and community health centers.

The final papers in this special issue consider strategies for evaluating WISEWOMAN projects, sharing important lessons and distilling best practices.[12–14] Finkelstein et al.[12] review the methods that are being used to evaluate WISEWOMAN's effectiveness and cost-effectiveness—the two outcome measures that "may be the most persuasive to stakeholders and policymakers." Their review (as well as the overview paper by Will et al.[1]) includes a discussion of WISEWOMAN's standard set of minimum data elements, selected to minimize the burden of data collection and allow cross-project analyses. The minimum data elements, collected for all participants at baseline and at the end of 1 year, focus on specific risk factors but can also be combined into a summary mea-

sure that assesses overall CVD risk. As Finkelstein et al. note, however, summary measures have limitations that make it important to also evaluate other indicators, which can provide additional evidence of program benefits.

Lewis et al.[13] provide a practical counterpoint to the discussion of highly quantitative evaluation techniques. The authors describe and recommend success stories, a qualitative evaluation strategy that can be used to document and communicate short-term program achievements to policymakers and public health professionals. As the authors note, it can take many years to achieve and measure reductions in morbidity and mortality, whereas success stories can immediately convey "how a program works, why it is successful, and how others can launch similar programs." In addition to describing the success story methodology, Lewis et al. provide several illuminating examples of ways in which the WISEWOMAN stories have contributed to policymaking and program planning.

Evaluation of the WISEWOMAN program is complex, given that it must consider a disparate group of projects that although united by a common goal, feature unique and varied intervention strategies. As Farris et al.[14] note in the concluding paper, a vitally important component of the WISEWOMAN evaluation plan is a comprehensive and rigorous effort to take stock of the diverse practices that characterize WISEWOMAN and identify which strategies are successful in the field. The goal is to cull best practices from the WISEWOMAN program that can be useful to other programs, and Farris et al. review the steps involved in the 3-year best practices evaluation launched by WISEWOMAN in 2003. To most effectively disseminate the best practices identified, the evaluation will culminate in a hands-on toolkit that "allows practitioners to select and adapt practices that best suit their specific situations and needs," the authors note.

This collection of papers summarizes many key lessons learned about the WISEWOMAN program.[15] Specifically, the papers address the program's ability to reach women in need and achieve and evaluate targeted behavioral and biological outcomes in multiple and challenging organizational contexts. The authors also identify crucial questions that must be considered as the program approaches its second decade. For example, how can projects fruitfully combine clinic-based screening, which by definition focuses on individuals and individual behavior change, with interventions that influence the social and environmental determinants of behavior? Is WISEWOMAN's clinic-based component manageable and sustainable in busy public health settings where provider turnover is high and resources are scarce? What is the best means of encouraging long-term behavior change? How can projects evaluate outcomes that occur at the community, organizational, and policy levels? Although this special issue provides some answers and recommendations, it also outlines much of the work that must be done to strengthen the WISEWOMAN program and make a lasting difference in women's health while maximizing the program's many documented successes.

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