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FOUR NEW CCOPS AWARDED TO FILL IN GEOGRAPHICAL GAPS—MISSISSIPI, FT. WORTH, FRESNO, VERMONT

NCI's Executive Committee last week approved four more Community Clinical Oncology awards, all based on giving the program better geographic distribution and filling in some gaps left in the award of the other 59. The four new awards will go to the Northern Mississippi Community On-

(Continued to page 2)

In Brief

SIMONE NAMED NEW DIRECTOR AT ST. JUDE; SCHEIN TO LEAVE GEORGETOWN FOR JOB AT SMITH-KLINE

JOSEPH SIMONE, associate director for clinical research at St. Jude Children's Research Hospital, has been named the new director of the internationally known childhood cancer center. He will replace Alvin Mauer, who will become director of oncology and hematology at the Univ. of Tennessee Center for Health Sciences next January. Simone, 47, has been at St. Jude for 15 years, is vice chairman of the Pediatric Oncology Group and a member of various other national cancer boards and committees. . . PHILIP SCHEIN, scientific director of the Vincent Lombardi Cancer Center at Georgetown Univ., will leave there at the end of this month to accept the position of vice president for research and development at Smith, Kline & French. Schein is chairman of the Mid-Atlantic Oncology Program, a regional cooperative group, and is the current president of the American Society of Clinical Oncology. . . NEW NATIONAL toll free phone number for reaching Cancer Information Service locations is 1-800-4-CANCER. There are 31 regional CIS offices at 22 institutions where staff members or volunteers answer cancer related questions from the public. Four locations are still using different numbers: Alaska, 1-800-638-6070; Washington D.C. and Maryland and Virginia suburbs, 636-5700; Hawaii, 524-1234; and New York City, 794-7982. . . LOUISE THOMSON, longtime executive secretary of the Clinical Cancer Program Project Review Committee, retired during the summer. Wayne Hurst, former NCI staff member, returned from the NIH Div. of Research Grants to take over that position. Three other review committees in NCI's Div. of Extramural Activities are still looking for exec secs—Cancer Special Program Advisory Committee, Cancer Clinical Investigation Review Committee, and Cancer Regional Studies Review Committee.

House May Add $80 Million To NCI Budget For FY 1984 . . . Page 2

New P01 Guidelines Will Go Into Effect Feb. 1, Not Oct. 1 . . . Page 3

New NCI RFAs . . . Page 4

RFPs Available . . . Page 8

FOUR NEW AWARDS, POSSIBLY MORE FROM REREVIEW WILL COMPLETE CCOP LINEUP

(Continued from page 1)

cology Program, Tupelo, Miss., Julian Hill, principal investigator; John Nugent, Community Clinical Oncology Program, Fort Worth, Texas, John Nugent, PI; San Joaquin Valley Community Clinical Oncology Program, Fresno, Calif., Phyllis Mowry, PI; and Green Mountain Oncology Group, Rutland, Vt., James Wallace, PI.

None of the original 59 CCOP awards were in Texas or Mississippi. The Fresno CCOP will be the only one between Los Angeles and Sacramento. Fresno's research base will be the Northern California Oncology Program and will be the only CCOP affiliated with NCOG, which probably was a factor in its selection even more than geography. NCOG was the only cooperative group without a CCOP affiliation. The Green Mountain CCOP will be the only one in Vermont, although New England is reasonably well represented, with two in Maine, two in Connecticut, one in Boston and several in upstate New York.

NCI had to skip over at least 20 CCOP applications with lower priority scores to make the four awards. That is not precedent setting, and NIH policy clearly provides that grants may be awarded without adhering strictly to scores. NCI stated at the outset that geography would be one of the considerations.

At least three of the new awards scored over 300. The score of the fourth was not available at press time. The Vermont score was 309, Fresno 316, and Mississippi 328.

Six other awards past the payline of 247 were included in the original 59, based for the most part on geography. They were in Las Vegas, Nev., with a score of 253; Charleston, W.Va., 262; Spartanburg, S.C., 260; Fargo, N.D., 274; Little Rock, 282; and Honolulu, 303.

The new awards will add an estimated $311,000 to the total CCOP budget, which had been estimated at a little more than $800,000 for the first 59, bringing the total estimated commitment to about $8.5 million. The figures are not definite because the indirect costs for the awards have not all been negotiated.

NCI had committed $10 million to the program, and the possibility exists that not all of that amount will be required out of the FY 1983 budget.

There still may be a few more awards, however. NCI completed the rereview of a few unfunded applications last week. Those were proposals which, staff felt, should have an additional review because of mistakes or technical errors made the first time. The results of the rereview will be presented to the National Cancer Advisory Board Oct. 4, and some additional awards could come out of that. That could edge the total CCOP budget closer to $10 million, but probably would not exceed $9 million.

That probably will be it for CCOP awards for this round. NCI executives are leaning toward the attitude of "Let's go with these and make the program work." If it does, some additional money might be committed for more CCOPs within two-three years, if NCI and/or Congress can be convinced the country needs more. In any case, the present awards will be recompeted after five years, giving other organizations another shot at it.

Separate NCAB approval was not required for the four new awards because staff had informed the Board at the May meeting that it intended to make a few more awards on a geographical basis, and the Board concurred.

The prospect remains that some organizations with CCOP awards will pull out of the program, as did the Evansville, Ind., CCOP (The Cancer Letter, Sept. 9). At present, there are no plans to replace Evansville by picking up one of the unfunded applicants, although NCI Director Vincent DeVita did say, "There's a long line waiting for any that are turned in." If there are more withdrawals, NCI might have to reconsider, but as it now stands, the Evansville money is going back into the pot.

HOUSE MAY ADD $80 MILLION TO NCI '84 BUDGET OVER PRESIDENT'S REQUEST

The prospect became apparent this week that the House of Representatives may add as much as $80 million to the President's 1984 fiscal year budget request for NCI.An increase of that size, if not encumbered with too many earmarks, would go a long way toward remedying deficiencies in projected Cancer Program funding during the next year.

The Labor/HHS Appropriations Subcommittee completed work on the 1984 money bill in

July, with the markup session behind closed doors. The subcommittee attempts to keep figures secret until after the full Appropriations Committee produces a finished bill. In most years, there are leaks, but this year, security was especially tight, and the subcommittee's markup figures were not even leaked to other congressmen.

There may have been at least one leak, however. Last week, "Aging News Research & Training" newsletter published what it claimed was the subcommittee's figures for the NIH total budget and for each institute. The figure for NCI: $1.045 billion (specifically, one billion, 44 million, 868 thousand). That did not include research training, which was left out of the subcommittee's bill for the moment. The President's budget request for training was $22.8 million.

Adding the figures would give NCI a total of $1.0676 billion, $81 million more than requested by the Administration. That would be enough to restore the money cut from the cancer centers core grant budget, assuring funds for all 20 of the core grants up for renewal in 1984; pay full indirect costs; pay all grants at their full recommended levels; and possibly add substantial amounts for intramural research, training programs, cancer control, clinical research, and construction. Some additional money also probably would be used to extend the payline for grants, now estimated at 170-175.

The subcommittee reportedly allocated $4.2 billion to NIH overall, an increase of $400 million over the President's request.

The figures are subject to change by the full committee, of course. The committee seldom cuts back subcommittee requests for NIH, and if anything, would add to them. It is not likely, either, that the NIH amounts would be cut when the bill goes to the House floor.

It is in the Senate where the major questions remain. The Labor-HHS Appropriations Subcommittee there has not marked up its bill. Historically, the Senate has added to the House figure for NCI.

Final action most certainly will not come before the new fiscal year begins Oct. 1. HHS probably will be operating on a continuing resolution until the legislation is final and is signed by the President.

NEW P01 GUIDELINES WILL NOT GO INTO EFFECT FOR OCT. 1; COPIES AVAILABLE

Contrary to an announcement published last month by NIH, the new guidelines for NCI program project grants will not go into effect for the Oct. 1 round.

The announcement said that the guidelines, developed by the National Cancer Advisory Board (The Cancer Letter, May 27) would be in force for applications submitted for the Oct. 1 deadline. NCI staff decided that would not give applicants a reasonable opportunity to develop proposals which conform to the new requirements. They will be in effect for the following cycle, with the Feb. 1 deadline.

The new guidelines are being printed and will be available on request from Referal Officer, Grants Review Branch, Div. of Extramural Activities, NCI, 2115 E. Jefferson St., Room 401, Rockville, Md. 20852.

There are six major changes, in requirements and emphasis, in the new guidelines:

1. Letters of intent are strongly recommended, to be submitted four to six months in advance of the application deadline. They are not mandatory, but the NCAB and NCI staff are convinced that by permitting staff to help guide investigators in preparing their proposals, better proposals will result.

2. Advance copies of the application must be submitted to DEA at the same time they are sent to the NIH Div. of Research Grants. This is designed to permit NCI staff an earlier look at the proposals.

3. It will be the responsibility of the principal investigator to develop tightly focussed, synergistic proposals. Individual subprojects disapproved by the review committees will not be thrown out by the reviewers but will be considered in the overall review, thus decreasing the chances for funding of the entire program project.

4. The review of individual subprojects will consider them in the context of the entire program project. Those which are weakly related to the program's objectives, which are not "synergistic," will be downgraded or disapproved.

5. The priority score will be awarded for the entire program; individual projects will not be scored, but all projects proposed together will be considered in the score.

6. The NCAB felt that many projects lose

much of their cohesion because they are too large. To limit the size, the new guidelines suggest that as a rule of thumb, proposals should not exceed that which can be presented to site visitors in a single day.

RFAs ISSUED BY NCI

The following Requests for Applications have been issues by NCI:

RFA NIH-NCI-DRCCA-OD-83-8

TITLE: The Use of Self Help Strategies in Smoking Prevention and Cessation
APPLICATION RECEIPT DATE: Dec. 1
LETTER OF INTENT RECEIPT DATE: Oct. 15

The Smoking, Tobacco & Cancer Program is interested in supporting studies directed at reducing the long term incidence/prevalence of cigarette smoking through the use of self help strategies.

Proposed studies should seek to (1) develop and evaluate individual and/or group self help strategies to eliminate, prevent, or reduce cigarette smoking and/or (2) develop and evaluate assessment procedures for determining the long term effectiveness of existing self help strategies in eliminating, preventing, or reducing cigarette smoking.

Since the first Surgeon General's report on the health consequences of cigarette smoking was published in 1964, an estimated 30 million people have quit smoking. Subsequent reports have suggested that a significant majority of those who have stopped smoking have done so without the aid of organized smoking cessation programs and that most current smokers prefer to quit with a procedure they may use on their own.

In response to this preference, a number of self help smoking interventions has been developed over the past decade. These strategies have included the use of pamphlets, manuals and books, audiotape cassettes, and mass media messages and presentations.

Unfortunately, most self help interventions have not been systematically evaluated. Existing studies have not identified which self help strategies or programs are most effective, which types of self help materials are most effective with smokers during different stages fo change (e.g., pre-quitting, decision making, quitting and maintenance), what generalizations may be drawn across self help strategies, under what conditions smokers make use of available self help materials, and what interactions may exist among self directed change, changes in an individual's environment, and environmental factors that may facilitate or interfere with self quitting.

Although some valuable data have been obtained regarding self-initiated smoking interventions (e.g., identification of factors related to successful and unsuccessful self quitting), a substantial gap exists in how to apply this information across broad populations and achieve long lasting results.

Focus of the studies envisioned must be on the long term effectiveness of self help strategies. It is anticipated these studies will be phase III and phase IV. Where justified and necessary, however, highly controlled studies of the acquisition process, personality factors or other related research questions which could influence the self help process may be embedded in the intervention studies. These research questions should not become the overriding interest of the study.

Studies sought are of two broad types:

A. Development and long term evaluation of the effectiveness of individual and/or group self help strategies to eliminate, prevent, or reduce cigarette smoking; and

B. Development and long term evaluation of assessment procedures for determining the effectiveness of existing, well designed self help strategies to eliminate, prevent, or reduce cigarette smoking.

Prospective investigators should note (1) that the outcome measure of these studies should be incidence of smoking bevavior, not cancer incidence; and (2) that the desired overall outcome of studies eventually supported through this RFA are interventions that are a) cost beneficial; b) cost effective; c) durable in their effects; d) generalizable; and e) readily adoptable and affordable by those desiring to do so.

Considering the current state of the art in self help smoking interventions, as well as the aims of this RFA, studies of the broad types called for above should consider, and address where appropriate, the following research questions and issues (as well as numerous others not listed):

- Can self help intervention programs produce long term cessation, reduction, prevention of cigarette smoking? And, is the popuation and/or technique chosen for this study sufficiently stable to permit such long term followup?
- Is the research design and data analysis plan rigorous enough to provide valid, reliable data yet flexible enough to accommodate field setting conditions?
- Is there a sufficient number of individuals or groups to insure, to the extent possible, that any observed effects are linked to the intervention?
- Is there sufficient justification (i.e., validity, reliability data) for the selection of intervention materials to be utilized or developed?
- Is the process evaluation design able to monitor the implementation of key intervention components, identify which are most responsible for any intervention impact, and determine which are best/least well received by intervention participants?
- What type of self report validation techniques are appropriate for the interventions planned?
- Is it possible to identify and design appropriate self help intervention for individuals who are at particularly high risk for starting or continuing habitual cigarette smoking?
- Are specific self help techniques needed for interventions with individuals who are non-middle class, minority, highly mobile, or less educated? How will sociocultural differences in the study population affect the study design?
- Is there a role for the family or other support groups in self help smoking intervention programs? If so, how could these groups be integrated into such efforts?
- How do environmental factors (e.g., peer smoking status, community attitudes) interact with program components and affect impact of interventions?
- Will these interventions be more effective if they are designed as specific smoking self help approaches or embedded within broader health behavior self help approaches? Which type of approach are individuals more likely to utilize after the research has been completed?
- How useful are booster sessions in achieving long term effects? How often are they needed? What should their focus be?
- What consideration must be given to the multiple domains of individual health and social behavior (e.g., psychological health, problem behaviors other than cigarette smoking, personal adjustment factors) in the design, content, and

material development of the interventions?

- Can effective self help intervention programs be sufficiently standardized or packaged so that they can be successfully used by a broad range of individuals in the absence of continuing external involvement?
- What is the optimum time needed for a self help intervention to have a positive impact? What type of individual and what level of smoking involvement are the most appropriate for intervention?
- How should a self help intervention approach the issue of smoking relapse?
- Is it possible that there may be a reaction effect to self monitoring in these interventions and, if so, how might this affect the research?
- Have the broad range of self help intervention delivery methods (e.g., in person, mail, computer, mass media) been considered?
- Is it possible to determine why self quitting seems to be the most effective method of smoking cessation and thus identify individuals who may be in a pre-quitting stage and most amenable for a successful self help program?

Total project period of applications submitted should not exceed five years; nevertheless, it is NCI's intent to support quality studies to their completion. Where more than five years is required, and the case is made for such, the possibility for longer studies will exist through competing renewal grant applications. Intent is to fund up to five projects, with total costs for all projects amounting to approximately $1.4 million the first year.

Prospective applicants are asked to submit a one page letter of intent which includes a very brief synopsis of proposed areas of research and identification of any other participating institutions. This letter should be sent to Dr. Thomas Glynn, Program Director for Smoking Research, DRCCA, National Cancer Institute, Blair Bldg. Rm. 101, Bethesda, Md. 20205, phone 301-427-8735.

Applications must be submitted on Form PHS 398. The words "Proposal in Response to RFA NIH-NCI-83, The Use of Self Help Strategies in the Prevention and Cessation of Smoking" must be typed in bold letters in space number 2 on the face page of the application.

The completed original application and six copies should be sent or delivered to the Div. of Research Grants, National Institutes of Health, Westwood Bldg. Rm. 240, Bethesda, Md. 20205. Inquiries may be directed to Dr. Glynn.

RFA NIH-NCI-DRCCA-OD-83-9

TITLE: Evaluation of Physician/Dentist Delivered Interventions for Smoking Prevention and Cessation

APPLICATION RECEIPT DATE: Jan. 1, 1984

LETTER OF INTENT RECEIPT DATE: Oct. 15, 1983

The Smoking, Tobacco & Cancer Program is interested in supporting studies directed at reducing the long term incidence/prevalence of cigarette smoking by enhancing the effectiveness of physicians and dentists in prevention and cessation counseling and support.

Proposed studies should seek to (1) identify/-develop, implement, and evaluate brief structured interventions for physicians and dentists to assist their patients with smoking prevention or cessation; and/or (2) develop and evaluate mechanisms to encourage physician and dentist utilization of smoking prevention and cessation interventions; and/or (3) develop and evaluate mechanisms to encourage patients to request assistance with smoking cessation from their physician or dentist.

Physicians and dentists are in a unique position to influence patients to change their smoking habits. Not only do they enjoy prestige and credibility as sources of health related information, but there also is evidence that these groups are receptive to playing an increasing role in discouraging smoking. Preliminary data on the role that physicians may play in smoking intervention are encouraging, but they raise important questions about the nature, importance and efficacy of provider influence. We know very little about such issues as the most effective methods physicians and dentists can use to motivate patients to consider cessation and to assist patients in actually quitting and maintaining nonsmoking, about what kinds of patients are most readily influenced by provider messages, and what is involved in encouraging patients to request assistance concerning smoking from their physician or dentist. It is to these and numerous other related issues that this RFA is addressed.

Purpose of this RFA is to solicit applications from qualified investigators interested in developing (or implementing already existing) physician/dentist delivered smoking interventions and determining the long term effectiveness of these programs on the durable prevention, reduction, and cessation of cigarette smoking among patient populations.

Focus of the studies envisioned thus must be on the long term effectiveness of physician/dentist interventions. It is anticipated that studies funded under this RFA will be phase III (i.e. controlled studies of cancer control interventions in sizeable groups which may not, however, be representative of the larger population) and phase IV (interventions designed and carried out with a distinct and well characterized population or a sizeable sample of the population in such a way that the results obtained are representative of results in the large target populations) investigations.

Where justified and necessary, highly controlled studies of the acquisition process, physician/-dentist attitudes or other related research questions which could influence the effectivenes of provider messages may be embedded in the intervention studies. These research questions should not become the overriding interest of the study.

Objective is to increase the effectivness of physicians/dentists in providing smoking prevention and cessation interventions to their patients. The primary focus is on the role of physicians and dentists in smoking interventions, although other health professionals (nurses, dental hygienists, pharmacists) may be included. No restrictions are set on physician, dentist, or patient populations, nor on settings or organizations (HMOs, worksites, clinics and general specialty practice) that may be studied. Applicants are encouraged to seek the cooperation of physician/dentist professional organizations in obtaining large numbers of these professionals for study participation.

Prospective investigators should note (1) that the outcome measure of these studies should be incidence of smoking behavior, not cancer incidence; and (2) that the desired overall outcome of studies eventually supported through this RFA are interventions that are a) cost beneficial; b) cost effective; c) durable in their effects; d) generalizable; and e) readily adoptable by a broad range of physicians and dentists.

Considering the current state of the art in physician/dentist smoking interventions, as well as the aims of this RFA, studies of the broad types called for above should consider and address where appropriate, the following research questions and issues (as well as numerous others not listed, depending on factors specific to the proposed study's objectives):

—Can physician/dentist intervention programs pro-

duce long term reductions in smoking behavior? And, is the population and/or technique chosen for this study sufficiently stable to permit such long term followup?

—Is the research design and data analysis plan rigorous enough to provide valid, reliable data yet flexible enough to accommodate field setting conditions?

—Is there a sufficient number of individuals or groups to insure, to the extent possible, that any observed effects are linked to the intervention?

—Is there sufficient justification (i.e., validity, reliability data) for the selection of intervention materials to be utilized or developed?

—What consideration must be given to the multiple domains of individual health and social behavior (e.g., psychological health, problem behaviors other than cigarette smoking, personal adjustment factors) in the design, content, and material development of the interventions?

—Can effective intervention programs be sufficiently standardized or packaged so that they can be successfully used by a broad range of physicians/dentists in the absence of continuing external involvement?

—What is the optimum number of contacts needed for this intervention to have a positive impact? What type of individual and what level of smoking involvement is the most appropriate for intervention?

—How should this tupe of intervention approach the issue of smoking relapse?

—Is the process evaluation design able to monitor the implementation of key intervention components, identify which are most respnsible for any intervention impact, and determine participants?

—What type of self report validation techniques are appropriate for the interventions planned?

—Is it possible to identify and design appropriate interventions for individuals who are at particularly high risk for starting or continuing habitual cigarette smoking?

—Are specific techniques needed for interventions with individuals who are non-middle class, minority, highly mobile, or less educated? Do the interventions consider sociocultural differences among the participants?

—Is there a role for the family or other support groups in physician/dentist smoking intervention programs? If so, how could these groups be integrated into such efforts?

—How do environmental factors (e.g., physician/-dentist smoking status, community attitudes) interact with program components and affect the impact of the interventions?

—Will these interventions be more effective if they are designed as specific smoking interventions or embedded within broader health behavior approaches? Which type of approach are physicians/-dentists more likely to utilize after the research has been completed?

—How useful are booster sessions in achieving long term effects? Can they be integrated into this type of program? How often are they needed? What should their focus be?

—How do physician/dentist smoking behavior, perceptions and attitudes affect their effectiveness as intervenors?

—How does the physician/dentist's views of their patients' ability to control their smoking affect their effectiveness as intervenors?

—How will physician/dentist compliance with the interventions be monitored?

—Will health professionals other than physicians/dentists be involved in the intervention? What will their roles be?

Total project period for applications should not exceed five years; nevertheless, it is NCI's intent to support quality studies to their completion. Where more than five years is required, the possibility for longer studies will exist through competing renewal grant applications. Intent is to fund up to five projects, with total costs for all projects amounting to approximately $1.3 million for the first year.

Prospective applicants are asked to submit a one page letter of intent which includes a very brief synopsis of proposed areas of research and identification of any other participating institutions. This letter should be sent to Dr. Glynn, address in previous RFA.

Application must be submitted on Form PHS 398. The words "Proposal in Response to RFA NIH-NCI-DRCCA-OD-83-9, Evaluation of Physician/Dentist Delivered Interventions for Smoking Prevention and Cessation" should be typed in bold letters in space number 2 on the face page of the application.

The completed original application and six copies should be sent or delivered to DRG, address in previous RFA. Inquiries may be directed to Dr. Glynn.

RFA NIH-NCI-DRCCA-OD-83-10

TITLE: Development and Evaluation of Smoking Prevention and Cessation Interventions Using the Mass Media

APPLICATION RECEIPT DATE: Jan. 1, 1984

LETTER OF INTENT RECEIPT DATE: Oct. 15, 1983

The Smoking, Tobacco & Cancer Program is interested in supporting studies to determine the long term effect of mass media interventions designed to prevent the onset and/or reduce the prevalence of cigarette smoking behavior.

Proposed studies should seek to (1) develop and evaluate innovative techniques that significantly increase the long term effect of single or multiple mass media interventions for smoking prevention or cessation; and/or (2) develop and evaluate innovative techniques for the reinforcement and maintenance of positive prevention and cessation behaviors generated as a result of mass media interventions; and/or (3) provide for the long term follow-up of study cohorts and their controls who have been a part of previous mass media interventions directed at smoking prevention and cessation.

Among the many approaches to smoking prevention and cessation available, it is the mass media which have the potential to reach many thousands of smokers at one time, offer a convenient and relatively inexpensive means for obtaining assistance with quitting, can substantially reduce the burden of providing such assistance through the health care system, and contribute to developing a social climate that is more supportive of prevention and cessation behavior. Mass media campaigns directed at smoking behavior have been used with increasing frequency in recent years. However, few studies have been conducted to asess the effects of specific campaigns. Those that have been done most often reveal minor, short term effects on behavior change, but even the majority of these studies have been criticized for various aspects of their study design. Beyond that, little is known about the long term effects of these interventions, and such issues as the relative effectiveness of their various components, their cost effectiveness, and their generalizability. It is to these and other related issues which this RFA is addressed.

Purpose of this RFA is to solicit applications from qualified investigators interested in developing media based smoking intervention programs (or following up already existing ones) and determining the long term effectiveness of these programs on the prevention and cessation of habitual cigarette

smoking among defined populations.

Focus of the studies envisioned thus must be on the long term effectiveness of media based interventions. It is anticipated that studies funded under this RFA will be phase III and Phase IV investigations. Where justified and necessary, highly controlled studies of the acquisition process, personality factors or other related research questions which could influence the effectivenss of the media process may be embedded in the intervention studies.

Studies sought are of two broad types:

A. New studies of promising media based intervention programs (focused either on broad, defined populations or on specifically targeted populations) which incorporate longitudinal followup (no less than one year following conclusion of the intervention; wherever justified, longer periods of followup to measure durability of intervention effects are encouraged).

B. Longitudinal followup of existing cohorts which have been part of a well designed media based intervention program but have been subjected only to short term evaluation, and whose size and composition justify generalizable conclusions.

Prospective investigators should note (1) that the outcome measure of these studies should be incidence of smoking behavior, not cancer incidence; and (2) that the desired overall outcome of studies eventually supported through this RFA are interventions that are a) cost beneficial; b) cost effective; c) durable in their effects; d) generalizable; and e) readily adoptable by others with only minor modifications and little or no external aid.

It is recognized that media based experimentation with long term followup is a difficult and complex task. Considering this and the current state of the art in media based smoking interventions, as well as the aims of this RFA, studies of the broad types called for above should consider, and address where appropriate, the following research questions and issues (as well as numerous others not listed, depending on factors specific to the proposed study's objectives):

—Can media based intervention programs produce long term effects on smoking behavior? Is the population and/or technique chosen for this study sufficiently stable to permit such long term followup?

—Is the research design and data analysis plan rigorous enough to provide valid, reliable data yet flexible enough to accommodate field setting conditions?

—Is there a sufficient number of individuals or groups to insure, to the extent possible, that any observed effects are linked to the intervention?

—Is there sufficient justification (validity, reliability data) for the selection of intervention materials to be utilized or developed?

—Is the process evaluation design able to monitor the implementation of key intervention components, identify which are most responsible for any intervention impact, and determine which are best/least well received by the intervention participants?

—What type of self report validation techniques are appropriate for the interventions planned?

—Is it possible to identify and design appropriate interventions for individuals who are at particularly high risk for starting or continuing habitual cigarette smoking?

—Are specific media approaches needed for interventions with individuals who are non-middle class, minority, highly mobile or less educated? How will sociocultural differences in the study population affect the study design?

—Is there a role for the family or other support groups in media based smoking intervention programs?

—How do environmental factors (time of year, community attitudes) interact with program components and affect the impact of the interventions?

—Will these interventions be more effective if they are designed as specific smoking approaches or embedded within broad health behavior approaches? Which type of approach are those with media access more likely to utilize after the research has been completed?

—How useful are booster campaigns in achieving long term effects in media based interventions? Are they feasible? How often are they needed? What should their focus be?

—What consideration mut be given to the multiple domains of individual health and social behavior (psychological health, problem behaviors other than cigarette smoking,personal adjustment factors) in the design, content, and material development of the interventions?

—Can effective media based intervention programs be sufficiently standardized or packaged so that they can be afforded and successfully used by a broad range of groups in the absence of continuing external involvement?

—What role will message and copy testing play in the study design?

—Will these interventions be more effective if they are conducted through media approaches alone or in conjunction with other smoking prevention/cessation efforts?

—What is the most effective programming tool to use for attracting and sustaining participation of smokers who want to quit? Are, for example, nightly news segments better than half hour programs broadcast over several weeks? Given the advantages and disadvantages of each of these approaches, how can they be used to achieve more effective results? Are there other programming formats that may be effective?

—Which medium or combination of media (radio, television, newspapers) is the most effective? How can cable television be utilized for this purpose?

—What are the most effective promotion and publicity strategies for reaching those less predisposed to quit smoking?

—How cost effective is the use of mass media for conducting smoking cessation clinics? How can their cost effectiveness be improved?

—What types of media and/or interpersonal interventions would be effective for fostering maintenance of nonsmoking behavior? Would PSAs, for example, be adequate maintenance messages?

—In what ways can the broadcast and print materials be utilized beyond their original use? For example, what are the effects of repeated broadcasts? How effective are these materials when used as "small media" by work sites, community groups, health care professionals?

—What are the most effective approaches for developing and distributing the printed materials that accompany the broadcast programming?

—Which program formats work best—for example, use of an expert who instructs the audience in smoking cessation skills or use of a panel of smokers participating in a clinic? To what extent would an interactional component such as a live telephone call-in system enhance the effectiveness of the media intervention?

Total project period for applications submitted should not exceed five years. It is NCI's intent to support quality studies to their completion. Where more than five years is required, the possibility for longer studies will exist through competing renewal grant applications. Intent is to fund up to five projects, with total costs for all projects amounting to approximately $1.8 million for the first year.

Prospective applicants are asked to submit a one page letter of intent which includes a very brief

synopsis of proposed areas of research and identification of any other participating institutions. This letter should be sent to Dr. Glynn, address in first RFA.

Applications must be submitted on Form PHS 398. The words "In Response to RFA NIH-NCI-DRCCA-83, Development and Evaluation of Smoking Prevention and Cessation Interventions Using the Mass Media" should be typed in bold letters in space number 2 on the face page of the application.

The completed original application and six copies should be sent or delivered to DRG, address in first RFA. Inquiries may be directed to Dr. Glynn.

RFPs AVAILABLE

Requests for proposal described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. NCI listings will show the phone number of the Contracting Officer or Contract Specialist who will respond to questions. Address requests for NCI RFPs, citing the RFP number, to the individual named, the Blair building room number shown, National Cancer Institute, NIH, Bethesda, MD. 20205. Proposals may be hand delivered to the Blair building, 8300 Colesville Rd., Silver Spring, Md., but the U.S. Postal Service will not deliver there. RFP announcements from other agencies will include the complete mailing address at the end of each.

RFP NCI-CP-41001-72
Title: Synthesis of selected chemical carcinogen standards
Deadline: Nov. 4

The Chemical Research Resource Program of NCI is interested in selecting a small number of contractors with the requisite skills to prepare selected chemical carcinogens and certain of their derivatives for the NCI Chemical Carcinogen Reference Standard Repository to be distributed to the scientific community for use as reference standards.

The compounds of interest include polynuclear aromatic hydrocarbons and their derivatives, nitrosamines, aromatic amines, and others. Some radiolabeled compounds (^{3}H and ^{14}C) will be required.

The offeror shall prepare designated compounds by unequivocal methods to produce gram quantities of highly purified, well characterized materials. For compounds for which synthetic route and yield are not well established by modern methods, the compounds are to be prepared in exploratory synthesis on a small scale and then prepared in a production run to yield the required number of grams at sufficient purity.

Compounds shall be characterized by a meaningful combination of appropriate techniques including possibly infared and ultraviolet visible spectrophotometry, melting point, then layer chromatography, elemental analysis, NMR, GC/Mass spectroscopy, and optical rotation.

Multiple awards are anticipated. This effort is currently being performed by Midwest Research Institute and SRI International.
CONTRACT SPECIALIST: Jackie Ballard
RCB Blair Bldg Rm 114A
301-427-8888

RFP NCI-CM-47649-68
Title: Provision, maintenance, and transfer of tumor bearing laboratory animal models for investigations
Deadline: Nov. 4

The Clinical Oncology Program, Div. of Cancer Treatment, NCI, is seeking an organization qualified to maintain experimental laboratory rodents for investigators located on the NIH campus. The contractor shall provide housing and maintenance of both normal and experimental and manipulated rodents, provide technical support in experimental manipulations and recording of health and mortality data and provide appropriate veterinary support to ensure the health of the experimental animals. The contractor shall provide daily transportation of animals between the contractor's facilities and the NIH campus including both a morning and an evening trip as necessary and provide unrestricted access to the animals by authorized investigators.

As a minimum requirement, the contractor must be located within a 35 mile radius of the NIH main campus as investigators will frequently transport chemical and pharmaceutical reagents as well as biological preparations from laboratories located on the NIH campus to the contractor's animal facility for experimental manipulations. It is expected that one award will be made for five years.
CONTRACT SPECIALIST: Karlene Wakefield
RCB Blair Bldg Rm 212
301-427-8737

NCI CONTRACT AWARDS

TITLE: Support services for FDA requirements
CONTRACTOR: Social & Scientific Systems Inc, Washington D.C., $1,777,357.

TITLE: Provision of tissues and cells and conduct of routine tests in support of tumor cell biology studies
CONTRACTOR: Litton Bionetics, Kensington, Md., $1,731,347.

TITLE: Bioassay by tracheal organ culture system
CONTRACTOR: IIT Research Institute, $273,558.

NEW PUBLICATIONS

"Cooking for the Cancer Patient," compiled by Kato Perlman and Jerry Kukachka. A collection of high protein, nutritional recipes designed to help counteract loss of appetite. Univ. of Wisconsin Center for Health Sciences, Patricia Hoopes, Cancer Information Service, 1300 University Ave., 7C, Madison 53706, $5.

"Cancer in Man," edited by Bodmer, $26.95. Oxford University Press, 200 Madison Ave., New York 10016.

"New Anticancer Drugs: Mitoxantrone and Bisantrene," edited by Marcel Rozencweig, Daniel Von Hoff, and Maurice Staquet. Raven Press, 1140 Ave. of the Americas, New York 10036, $25.

The Cancer Letter _Editor Jerry D. Boyd

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