THE CANCER LETTER

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Number Of Clinical R01 Applications Doubles, Funding Rate Below 20%; NCI Execs Not Satisfied

Preliminary data are in for the first year of NCI's effort to encourage clinically oriented investigator initiated research, but while more clinical R01 grant applications are being submitted, reviewed, and funded, the numbers so far are no cause for celebration, NCI officials have indicated.

In fact, the numbers tend to raise more questions than they can answer at the moment. NCI's Div. of Cancer Treatment has been charged with providing a more detailed analysis of the types of clinical applica-

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In Brief

CDP Services Wins ASCO Planning Contract; Jury Finds Sarin Guilty Of Embezzlement

CDP SERVICES of Atlanta, GA, has won a contract from the American Society of Clinical Oncology to conduct a strategic planning project. CDP conducted a strategic plan for ASCO two years ago that resulted in the society establishing its Washington office and enhancing its work on clinical practice issues. Major focus of the new project will be to examine the structural organization of the society and its staffing. Chairman of ASCO's strategic planning committee is **Robert Young**; contractor selection was completed under the chairmanship of **Charles Coltman**. . . . **PREM SARIN**, former deputy chief of NCI's Laboratory of Tumor Cell Biology, was found guilty last week by a U.S. District Court jury in Baltimore of embezzling a $25,000 payment made by the German drug company Degussa/Asta Pharma and of making false statements on NIH financial disclosure forms. The jury found Sarin not guilty on a charge of supplementation of income. Sarin's attorney **Neil Eggelston** argued that Sarin intended to use the $25,000 and a promised second payment of the same amount to hire a technician to test D-penicillamine for Degussa. The prosecution argued that Sarin treated the money as his own and put the drug at the front of the line of drugs to be tested. On the charge of false statements, the defense argued that Sarin was not aware of changes in regulations. NCI Assistant Director **Elliott Stonehill** testified that the Institute encouraged speed more than accuracy when an employee filed a request for approval of outside activities. Under cross-examination, Stonehill said he was "wrongly accused of sexual molestation" is on temporary reassignment in the Div. of Extramural Activities pending an investigation. Stonehill declined to comment further to **The Cancer Letter** this week. . . . **SAN ANTONIO** Annual Symposium on Cancer Research will be held July 24, San Antonio, TX. Contact Institute for Cancer Research and Care, phone 512/616-5590.

Clinical R01s: Numbers Increase, Funding Rate Below 20 Percent

(Continued from page 1)

tions that are being funded and what may be causing some clinical applications to fail.

"This has not been a completely satisfactory experiment," Cancer Therapy Evaluation Program Director Michael Friedman said to the DCT Board of Scientific Counselors at its recent meeting.

More than a year ago, NCI officials began talking about the need for funding more clinical cancer research through investigator-initiated research project grants, a funding mechanism that has grown nearly 30 percent in the past decade in real dollars. In contrast, funding for NCI's clinical cooperative groups mechanism lost 30 percent in the 1980s, as did prevention and control; cancer centers lost 15 percent.

"The research project grant is the most revered mechanism at NIH," Broder said last year to **The Cancer Letter** (Sept. 20, 1991). "It is the mechanism that is the most secure and grows the best."

Broder and other NCI officials began discussions with the NIH Div. of Research Grants, which controls the peer review of investigator initiated research, about the perception among clinical investigators that their applications were not faring well in comparison to basic cancer research proposals.

The DRG study section Experimental Therapeutics 2 (ET2) has been criticized by some clinical investigators for having a primarily basic research membership and focus. NCI asked DRG to form a new study section for clinical cancer research or to include more clinical researchers on ET2.

DRG Director Jerome Green told NCI that the study section was at present underutilized by clinical investigators, and that if the number of clinical applications increased, DRG would change the ET2 membership or consider forming a new study section (**The Cancer Letter,** March 8, 1991). Green also invited NCI to suggest names for ET2 membership.

Broder and other NCI executives then urged clinical investigators to "flood" the system with R01 applications.

The Data So Far

The number of clinical applications submitted has nearly doubled, according to data Friedman presented to the DCT board:

In 1991, ET2 received 36 applications involving clinical oncology, and seven were funded, for a 19 percent funding rate; in 1992, 69 applications were received and 13 were funded, also for a 19 percent funding rate.

In comparison, for biochemistry and pharmacology, 43 applications were received in 1991 and 10 were funded for a 23 percent funding rate; in 1992, 41 applications were received and 16 were funded, for a 39 percent funding rate.

Following are the number of applications submitted per grant round in 1992:

In round 1, prior to the Program Announcement CTEP issued inviting clinical oncology R01 applications, there were 24 applications, 21 of which proposed studies using human subjects, and 11 of which involved clinical trials.

In round 2, after the PA was issued, there were 53 applications, 46 of which involved human subjects and 28 of which proposed clinical trials.

In round 3, there were 69 applications, 59 of which involved human subjects and 43 of which proposed clinical trials.

The absolute number of clinical applications submitted was smaller than the number of those in biochemistry and pharmacology that ET2 also reviews. However, the biochemistry and pharmacology applications fared better, even though the committee "was sensitized" to the concerns of clinical investigators, Friedman said.

"There is a bias," Friedman contended. For example, one particular application proposed a study with a new agent; "we thought the application was good. But the review committee said there was no interest in this new agent. They said this was a useless drug."

"That's business as usual for all types of study sections," DCT Board Chairman Ronald Levy said.

"That's true, but when the section is trying to apportion time between basic and clinical research, it's a large area to cover," Friedman said. "It is not going to be as good a review."

"They just don't fare well," DCT Director Bruce Chabner said of the clinical applications. It may be

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that many were submitted by investigators inexperienced in the applications process, he said. "I don't think you can blame the study section; they are terrific people; there aren't a plethora of good ideas."

"We disagree," Friedman said.

"Don't you think we funded most of the exciting ideas?" Chabner asked Friedman.

Friedman deflected the question. "We will have the opportunity to discuss this fully (at the next board meeting in the fall). We don't have all the data in yet."

Chabner suggested that DCT staff prepare a detailed analysis of the types of applications that were funded and those that went unfunded.

Friedman commented that, "We don't want to have comparisons between basic and clinical research. We're not talking about an entitlement program for the handicapped clinician."

Roy Wu, CTEP health scientist administrator, told **The Cancer Letter** this week that it may be too early to judge whether the experiment is working. "The last two rounds were first in which there were lots of applications. It just takes time for the NCI Executive Committee to react to the situation and for the reviewers to react. It should take a two to three year trial," he said. "We are getting more clinical applications in, but funding rate is staying the same."

Wu said the funding rate for clinical oncology applications was less than 18 percent; however, the number of grants are so low that "one or two grants could swing the whole thing."

"We need to increase the quality of applications coming in, or the Executive Committee will have to pick up more exceptions," Wu said. NCI sets aside a certain amount of its research project grant budget to fund grants that fall outside the payline, but may contain important research ideas that fit program considerations.

Following are responses to CTEP program announcements up to last month that Wu provided to a meeting of the cooperative group chairmen recently:

--Surgical oncology (PA-91-16): 32 applications reviewed in 1991, 25 reviewed in 1992, seven to be reviewed, five funded; 20 percent funding rate.

--Clinical cancer therapy research (PA-91-42): 60 applications reviewed last year, 48 this year, 12 to be reviewed, nine funded; 19 percent funding rate overall in FY92.

Breaking down the funding by grant round, there were 25 applications in the January 1992 round, five were within the payline and one was funded as an exception, for a 24 percent funding rate. For the May round, there were 23 applications, one grant was within the payline and two were funded as exceptions for a 12 percent funding rate.

--Cancer therapy research in lung cancer (PA-91-83): three applications reviewed in round 1, two in round 2, one to be reviewed, zero funded.

--Small grants for lung, breast and ovarian cancer clinical trials (PA-92-06): 32 applications to be reviewed by ET2 last month, no information yet on numbers funded.

--Interactive research project grants for cancer (PA-92-29): nine applications to be reviewed (three sets of IRPGs), no information yet on numbers funded.

Following are a list of the active CTEP program announcements, in addition to those four above. Deadlines are Oct. 1, Feb. 1 and June 1:

National digital mammography development groups (PA-92-57); Novel non-ionizing radiation technologies (PA-92-45); MRS/MRI in cancer treatment (PA-92-86); Exploratory/developmental grants in cancer therapy (PA-92-66); AIDS-associated Kaposi's sarcoma (PA-92-76).

Status of P01s

Chabner provided the DCT board with an update on the status of program project grant (P01) funding within his division. The P01 grants have been vital to clinical researchers, but Congress specified that NCI should fund a certain number of grants at an average cost of $210,000, greatly curtailing NCI's ability to fund program project grants, he said. The Institute set a payline of 125 earlier this year for P01s.

Within DCT, 12 grants that met the payline received recommended levels of funding, "minus selective cuts based on scientific considerations," Chabner said.

"For grants with scores above this austere line, selective cuts were made in the scope of research funded, and in general a cap of $750,000 in total cost was established." DCT was able to fund eight additional grants for a total of 20 new and competing P01s this year, compared to 17 last year and 22 in 1990. The division also funded four former P01s as interactive R01s, resulting in a total of 24 "P01-type grants" funded through DCT this year.

Average cost of the 20 P01s funded was $1.2 million, above the average cost of $940,000 last year. "This increase occurred despite some major cuts in the eight grants funded as exceptions," Chabner said.

Chabner noted that DCT has more money invested in P01s than the other divisions--almost a third of its total grants budget is committed to P01s.

"Unless Congress changes its way of doing business, we will probably have even less flexibility to fund large P01s in the future," Chabner said. "Other institutes have set mandatory caps on the dollar

amounts of all P01s funded. Thus far this has not been necessary for NCI.

"What alternatives do investigators have?" Chabner continued. "Those who are comfortable with the interactive R01 mechanism can seek support through this means, although it does not lend itself well to tightly integrated projects that require central leadership and extensive common resources. A second alternative that is increasingly used by our investigators is to supplement their meagerly funded P01s with R01s derived from the unfunded portions of their grant, or with formal P01 supplements."

"Some of our best translational research is being done under the P01 mechanism. We are trying to encourage the same type of research through set-asides (RFAs) under the U01 title and expand funding under the umbrella of interactive R01s, but there is no way that we can protect or replace the existing P01 pool through these other types of grants."

ICCCR Loses Funding Source; DeVita, Crozemarie Resign, Programs Frozen

The founding chairman and source of operational funding for the highly visible International Council for Coordinating Cancer Research, Jacques Crozemarie, has resigned, followed by ICCCR President Vincent DeVita.

The group placed a freeze on its programs as the new president, Peter Fischinger, vice president for research at Medical Univ. of South Carolina, plots the group's future mission and searches for funds.

One program not expected to be affected by the organization's problems is its annual symposium, which will be financed partially through funds raised independently from ICCCR's founder and former chairman Crozemarie, whose Paris-based group, Assn. for Research on Cancer, raised $60 million in 1990.

"The ICCCR Charleston conference is alive, well and scheduled for October 12 through 14," said Fischinger, who will run the conference, which will follow the dedication of the Hollings Oncology Center in Charleston.

Troubles at ICCCR began in early June. Shortly after DeVita spoke on behalf of ICCCR to the House Appropriations Subcommittee on Labor, HHS & Education, a French representative made an unexpected appearance at the council's offices in New York.

The same day, three of the council's five employees were dismissed and urged not to discuss the firings, sources said. In early July, nearly a month after the staff cuts took place, a letter from Crozemarie reached the members of the board of directors.

"It is now time for me to leave the vacant chair to another leader who will have full power to define and implement the means to promote ICCCR actions," Crozemarie wrote. A copy of the letter was obtained by **The Cancer Letter.**

"When it was founded, ICCCR vocation was to become autonomous and independent after a reasonable (five year) investment period," Crozemarie wrote. "It was then clearly settled that ICCCR should not be maintained on a single source of funds basis."

Though Crozemarie's funding for the group's operating budget would end following a transition period this year, "we do intend to support international projects from the French side," Crozemarie wrote in his undated letter.

About a week later, on July 10, board members received a terse letter from DeVita:

"I am pleased to announce that Dr. Fischinger has agreed to assume the position as voluntary president of ICCCR effective 1 August 1992.

"Please accept my sincere thanks for your efforts on behalf of the IC during my term."

Attempts to reach DeVita, clinical professor at Memorial Sloan-Kettering Cancer Center, were unsuccessful.

In another development, former Surgeon General C. Everett Koop resigned from the ICCCR board of directors. A spokesperson confirmed Koop's recent resignation, but did not discuss the reasons for it.

Fischinger said he was not surprised by the pullout by the French.

"It wasn't a shock," he said to **The Cancer Letter.** "We certainly had a sense that an organization like the ARC has to ask itself, 'is this a good way to spend our funds?' And there was an element of retrenchment in their decision."

Fischinger said he remains a believer in the value of international coordination of cancer research and about the conferences ICCCR has financed to promote it.

"We have to see what we can do under reduced circumstances," Fischinger said. "We will keep the existing organization in place as we consider the scope of the operations."

As he plots strategy, Fischinger said his consultants would include Crozemarie. "Jacques has done wonderful things," he said. "He has been a single dynamic force behind this activity."

If the operating funds are found, Fischinger said he would like to develop a "truly international" organization. Ideally, this would include cultivating a stronger relationship with the Japanese, he said.

"There has been absolutely no change whatsoever

in the purpose and the objective of the organization," Richard Bernstein, ICCCR's general secretary said to **The Cancer Letter.**

"The staffing has changed because of reduction in our budget," Bernstein said. "Like any organization, we have to be concerned about cash flow." ICCCR is operated from the offices of Bernstein's Madison Avenue law firm.

Bernstein refused to discuss the group's budget and the part of it that was supplied by Crozemarie, but sources said the operating budget was between $700,000 and $800,000, all of it provided by Crozemarie's group. Since ICCCR's operating budget was not raised in the U.S., it is not a matter of public record.

Though its budget was surprisingly modest, ICCCR attained high visibility in cancer research.

Its publications were glossy and sometimes reminiscent of posters, its boards of directors and scientific advisors included scientific luminaries and political power brokers.

And, if anything, the group appeared to have gained in significance last year, when Crozemarie merged it with the European Council for Coordinating Cancer Research, transferring the worldwide activities into the New York office.

The Charleston conference, "Basic Insights that Impact Cure and Prevention of Cancer," will cover molecular genetics, treatment approaches, environmental carcinogenesis and risk reduction, cancer biology, immunological approaches to cancer prevention, and primary and secondary prevention. ICCCR can be reached at 212/319-6920.

NCI, Industry Launch $18M Program To Promote Eating Fruits, Vegetables

NCI and the Produce for Better Health Foundation officially launched a nationwide "5 A Day for Better Health" campaign to encourage Americans to eat a minimum of five servings of fruits and vegetables daily, at a Washington press conference recently.

NCI will provide $18 million for the program over the next five years, $16 million of which will fund four-year research grants to state and local groups to assess the impact of the campaign in communities. The remaining $2 million will be spent on promotional activities; about $400,000 of that will be spent this year. The grants are to be issued next April (RFA was published in **The Cancer Letter,** April 10).

NCI Div. of Cancer Prevention & Control Director Peter Greenwald said a number of studies have shown that a diet rich in fruit and vegetables has a protective effect against cancer.

"These studies conclude that for many cancers, persons with high fruit and vegetable intakes have about half the risk of cancer of people with low intakes," Greenwald said.

The Produce for Better Health Foundation, a produce industry organization, has contributed $500,000 to the program, and said it will make contributions of advertising space expected to amount to $15 million annually. More than 200 food retailer organizations representing more than 30,000 supermarkets have joined the program, the foundation said.

The 5 A Day program began in 1988 when NCI awarded the California Dept. of Health Services a grant for a cooperative program between public health groups and private industry. Seventeen supermarket chains in the state participated in the program. NCI expanded the program nationwide last year in collaboration with the fruit and vegetable industry.

NCI released the results of its 5 A Day baseline survey at the press conference. The telephone survey of more than 2,800 adults showed that only 8 percent of Americans knew they should eat five servings of fruit or vegetables daily. Two-thirds thought two or fewer servings were sufficient.

Other results of the survey:

--Only 23 percent of Americans now eat five or more servings of fruit or vegetables daily, leaving 77 percent (140 million Americans) who are not eating the minimum daily amount recommended.

--Men eat only about three servings of fruits and vegetables while women eat nearly four. About half of the men surveyed thought one serving was enough for good health, compared to a quarter of the women.

--Hispanic Americans eat only three servings a day, compared to a daily intake of about three and a half for black and white Americans.

--Less educated and lower income persons tend to eat fewer servings of fruits and vegetables.

--Americans over age 65 eat more fruits and vegetables--about four servings per day--compared to young adults, who eat only about three servings.

--People who eat more fruits and vegetables are also the least likely to prepare vegetables in fat or to add fats after cooking.

--People who eat more fruits and vegetables in childhood have a higher consumption on average as adults.

"The heart of the program simply is this: every American ought to eat five daily servings of fruit and vegetables," HHS Secretary Louis Sullivan said. "Five

a day is a minimum. If you can eat up to nine servings a day, all the better. It's a quick, easy, and very effective way to augment your health."

NCI defines a serving size as one medium fruit, six ounces of 100 percent fruit or vegetable juice, half a cup cooked or raw vegetables or fruit, one cup of raw leafy vegetables or a quarter cup dried fruit.

ACS Adopts Principles As Basis For Reform Of Health Care System

The American Cancer Society has adopted a "Statement of Principles for Health Care Reform" which advocates a system that would guarantee health care to all "regardless of employment status, ability to pay, or preexisting health conditions."

The statement, developed by the ACS Public Issues Committee and its Task Force on Public Policy and the Socioeconomically Disadvantaged, was approved by the committee and the Board of Directors at their June meetings in Portland. In effect, it places the Society squarely on record in support national and/or state legislation that would guarantee quality health care for everyone.

The statement of principles does not spell out any particular form of state or national health insurance the Society supports. Instead, the Public Issues Committee "will analyze state and federal proposals for the extent that they meet American Cancer Society principles," Task Force Chairman Jack Sherman said. "The committee can use these principles on Capitol Hill, to evaluate proposals, monitor progress, and assist Congress in the development of proposals."

Sherman's motion for committee approval of the statement of principles included this language: "Because national health reform probably will not happen soon, the (ACS) divisions are authorized to deal flexibly with state legislatures on their various proposals."

In a preamble to the statement, the Task Force wrote:

"The American Cancer Society believes that a health care delivery system should work in a way that makes it easy for people to obtain necessary care. Individuals should be empowered with the necessary information and tools to share responsibility for their own health care. As a nation, we must turn our attention to these serious unmet health care needs. The American Cancer Society believes that all Americans should have unimpeded and facilitated access to comprehensive quality health care services. This care includes cancer prevention and regular proper medical treatment and continuing medical care. It is the role of the American Cancer Society to focus the attention of policy makers at all levels of government on this problem, and participate in the debate by providing important information about the cancer control needs of poor and underserved Americans which can be incorporated into proposals for health care system expansion, reform, or restructure.

"The American Cancer Society believes that the United States is capable of delivering high quality, state of the art medical care to every citizen in the United States. The Society also believes that this point is well demonstrated by many components of our current health care delivery system which benefit a large segment of the population.

"The Society recognizes, however, that serious gaps exist in accessibility, affordability, and quality of health care for many Americans which must be addressed now by the nation as a whole. Health care reform in the United States must deal collectively with the complex and interrelated concepts of access, cost, and quality in health care. To sacrifice one concept for another simply postpones the debate and the ability to implement necessary comprehensive reforms.

"Thus, the American Cancer Society believes that a balanced approach to health care reform, encompassing elements of patient accessibility and nondiscrimination, affordability and availability of care, standardization of covered services, insurance market reform, system administration reform, health care cost containment, provisions for quality assurance, technology assessment and practice guidelines, and education of the public and health care professionals, will best achieve its goals with respect to the delivery of cancer prevention and control services in the United States."

The Statement of Principles for Health Care System Reform.

Eligibility

All persons have the right to health care, regardless of employment status, ability to pay, or preexisting health conditions.

Coverage and Benefits

The U.S. health care system must provide for continuity and portability of health insurance benefits to ensure universal access.

Coverage should address the continuum of care and include cancer prevention, early detection, diagnosis, treatment, rehabilitation, and long term care. More specifically, covered serves should include, but not be limited to:

***Cancer prevention**--regular, routine medical care to identify and reduce risks for cancer from

environmental and occupational exposures; information about lifestyle choices, including diet and nutrition, and the use of tobacco and alcohol; and limiting exposure to sunlight.

***Cancer early detection**--appropriate, cost effective cancer early detection tests for asymptomatic persons, according to guidelines of the American Cancer Society, the National Cancer Institute, and other appropriate medical experts; and targeted assessments for individuals and family members at high risk for cancer.

***Cancer diagnosis and treatment**--medically appropriate tests for the diagnosis of cancer; treatment for cancer which includes all medically appropriate prescription drugs, therapies, or modalities; clinical trials of experimental protocols; and related services.

***Cancer rehabilitation**--a range of services, including physical therapy, prostheses and medical devices, psychosocial counseling, occupational therapy, and all related services.

***Long term care**--chronic, rehabilitative, home based, nursing home, and respite care services to enhance the quality of life of cancer patients and their families. Emphasis should be placed on patient autonomy and responsibility. Avoid pauperization of the cancer patient and his or her family.

Delivery of Health Care Services

Encourage patient choice, autonomy, and responsibility for the cost and use of health care services through continued educational and other appropriate strategies.

Medical benefits should be provided in a variety of health care settings.

Health care delivery systems should be organized to reduce fragmentation of available community services.

Simplification of the System

All persons should have unimpeded and facilitated access to the health care system.

Administration of the U.S. health care delivery system should be simplified to reduce costs and maximize resources for actual health care services. Standardize billing, claims, and utilization review procedures to significantly reduce the administrative costs of health care delivery, to ensure uniformity in coverage and benefits, and to control fraud and abuse in the system.

Quality Assurance

Quality assurance standards should be required to ensure that tests are safe and effective.

Technology assessment and the development of medical practice guidelines should be encouraged to provide important information on the quality, effectiveness, and cost savings potential of cancer prevention and control services.

Cost Containment

To ensure access to health care for people confronted by the cancer problem, it is essential that appropriate cost containment strategies be implemented at all levels to control excessive health expenditures.

Administration and Financing

Administration of health care should be provided through an appropriate combination of public and private sector mechanisms that will improve access to such care.

The financing of universal health care should avoid placing disproportionate burdens on any individual or sector within society.

Costs And Resources

During the Public Issues Committee discussion of the principles, Oliver Beahrs commented that, while the principles "are excellent, to accomplish them will take resources. We will need to search out those elements that contribute to costs and to resources."

Robert Hutter was concerned that "it is not clear what we are doing in giving the divisions flexibility. I would like to add that we expect the divisions to pursue implementation vigorously."

"The divisions should track and creatively participate implementation of the principles," Benjamin Byrd said.

The statement of principles places "the American Cancer Society up front, a leader at all levels," commented Alan Davis, vice president for public issues.

"The principles provide us with the ammunition we need to go to elected officials and tell them, 'These are the American Cancer Society principles on these issues.' They are the glue for a single, unified national position, on national legislation, from which the divisions can draw to use at state levels. . . Various proposals will fly in one state and not in another."

Publisher Wins Court Order Preventing Cover-To-Cover Copying

"Gas Daily," a Washington-based newsletter owned by Pasha Publications, recently won what industry representatives believe is the first court order preventing cover-to-cover photocopying of a newsletter.

The order was issued by a U.S. district judge in Dallas as part of a settlement of a copyright infringement case Pasha Publications brought against Enmark Gas of Dallas.

The newsletter firm charged that Enmark was

making copies of its paid issue of "Gas Daily" ($947 per year) for employees and then faxing copies to other offices.

Other terms of the settlement were not disclosed.

RFPs Available

Requests for proposals described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. Address requests for NCI RFPs, citing the RFP number, to the individual named, the Executive Plaza South room number shown, National Cancer Institute, Bethesda MD 20892. Proposals may be hand delivered to the Executive Plaza South Building, 6130 Executive Blvd., Rockville MD.

RFP NCI-CP-33013-18

Title: Support services for radiation and related studies

Deadline: Approximately Sept. 1

NCI's Div. of Cancer Etiology, Epidemiology & Biostatistics Program, Radiation Epidemiology Branch, is seeking a contractor to provide support services for the conduct and management of epidemiologic investigations of cancer as directed by REB. This is a recompetition of a contract with Westat Inc.

The types of support are as follows: 1) Study initiation and liaison: determine parties whose cooperation or approval is necessary for implementation of the study (e.g. federal or state agencies, hospitals, laboratories or other NCI contractors), assist in obtaining cooperation or approval, and arrange for communication between parties. 2) Preparation of study materials and procedures including data collection forms, abstract forms, procedure manuals and other documents. 3) Data collection: identify study subjects who meet NCI criteria, trace study subjects for interview, obtain necessary permission to interview subjects and to mail questionnaires to subjects, procure death certificates, arrange for collection, delivery, storage and/or standard laboratory testing or assays on biological specimens as designated by project officer, and arrange for placement, collection and shipment of radon detectors. 4) Data preparation: develop or select exposure coding schemes, code information into computer readable form, and store data collection instruments. 5) Computer programming and data processing including preparing and editing information for analysis. 6) Study monitoring, quality control and reporting so that appropriate and valid data result.

This project will be for a five year period with an anticipated award data of June 30, 1993.

Contract specialist: Catherine Baker
RCB Executive Plaza South Rm 620
301/496-8611

RFA Available

RFA MH-92-11

Title: The role of the family in preventing and adapting to HIV infection and AIDS

Letter of Intent Receipt Date: Aug. 15

Application Receipt Date: Sept. 15

Little information is available about family processes on a wide variety of family configurations, including those that are at high risk for HIV infection. Results from studies funded under this RFA will be used to develop effective prevention efforts aimed at high risk individuals and their families or to enhance treatment efforts for families already coping with HIV infection.

Applications may be submitted by public and private, non-profit and for-profit organizations. Women and minority investigators are encouraged to apply. Support for applications submitted in response to this announcement will be through individual research projects (R01) of up to three years duration.

In fiscal 1993, a minimum of $1.8 million has been set aside for this RFA. The National Institute of Mental Health will provide a minimum of $1.4 million; the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism will each contribute a minimum of $.2 million to support three to five awards. Support may be requested for a period of up to three years. Continuation, noncompeting awards will be made, subject to availability of funds and progress achieved.

The following sections suggest areas of research to meet the health promotion and disease prevention objectives. Researchers responding to this RFA, however, need not limit themselves to these topics.

--Ethnic and Cultural Considerations: Cross-cultural variables deserve special consideration; the explicit investigation of cultural factors as an aspect of family adaptation to HIV infection is encouraged.

--Family Processes and the Course of Illness: Basic information on family systems and processes for all subpopulations of persons infected with HIV is needed to determine what family factors serve to increase or decrease risk factors for becoming infected and to minimize symptomatology (physical and mental health outcomes) at all points in the course of the illness.

Prospective applicants are strongly advised to contact an NIMH, NIDA, or NIAAA staff member in order to discuss the proposed research project prior to submission. Contacts:

Willo Pequegnat, Office of AIDS Programs, National Institute of Mental Health, Parklawn Building, Room 17C-06, 5600 Fishers Lane, Rockville, MD 20857; phone 301/443-7281.

Vincent Smeriglio, Clinical Medicine Branch, Div. of Clinical Research, National Institute on Drug Abuse, Parklawn Building, Room 11A-33, 5600 Fishers Lane, Rockville, MD 20857, phone 301/443-1801.

Kendall Bryant, Program Director for AIDS Studies, Prevention Research Branch, National Institute on Alcohol Abuse and Alcoholism, Parklawn Building, Room 13C-23, 5600 Fishers Lane Rockville, MD 20857; phone 301/443-6177.

NCI Contract Awards

Title: Development and production of parenteral dosage forms
Contractor: Ben Venue Laboratories Inc., Bedford, OH; $8,538,299.

Title: Cultivation of marine protista
Contractor: Univ. of Miami, $991,780.

Title: Prospective investigation of human papillomavirus infection and cervical dysplasia
Contractor: Kaiser Permanente Center for Health Research, Portland, OR; $1,631,071.

Title: Development of dosage forms and delivery systems for new drugs
Contractors: Univ. of Utah, $1,009,477; Univ. of Kansas, $1,194,526; Univ. of North Carolina, $983,208; Univ. of Arizona, $996,898.

Small Business Innovation Research Program awards:
Systex Inc., $49,433; I.S. Grupe Inc. ($50,000); Lexical Technology Inc. ($49,999); Birch & Davis Associates Inc. ($49,952).