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## Third Annual Summer Institute Attracts Attendees from Throughout Texas

The 2006 Summer Institute was held in Houston at the University of Texas School of Public Health from July 10th to 14th, 2006. Forty-nine attendees took part in one of two intensive learning tracks: Managing Public Health Emergencies; and Building Community Capacity for Public Health. Sessions focused on topics ranging the gamut from agroterrorism to building community collaborations. Participants represented organizations at the state, local, and national level, and ranged in experience from high schoolers learning for the first time about public health to seasoned health professionals honing their skills.

The Institute drew on faculty and resources from each of the TPHTC collaborating institutions and UT's


Center for Biosecurity and Public Health Preparedness (CBPHP). Invited presenters and panelists from around Texas and beyond also enriched the learning environment with their experiences and insights. Nationally-known guest speakers who keynoted the Institute included: Dr. Barney Turnock of the University of Chicago School of Public Health who set the big picture by speaking to "Top 10 Reasons Why We Face

*See **Summer Institute**, page 2*

# Public Health Opinion: Folic Acid and the Prevention of Birth Defects

Increasing a woman's intake of folic acid, a simple B vitamin, prior to conception and early in pregnancy, decreases her risk of having a baby with a neural tube defect (NTD). The two most common NTDs, anencephaly and spina bifida, have been important contributors to infant mortality and childhood morbidity. Thus the primary prevention of these defects has important public health implications.

In 1992, the US Public Health Service recommended that all women of childbearing age take 0.4 milligram (400 micrograms) of folic acid per day. In 1998 the recommendation was subsequently clarified by the Food and Nutrition Board of the Institute of Medicine, following a review of the issue, to state: "to reduce their risk for an NTD-affected pregnancy, women capable of becoming pregnant should take 400 micrograms of **synthetic** folic acid daily, from fortified foods or supplements or a combination of the two, in addition to consuming food folate from a varied diet."

The IOM recommendation highlighted the two preventive interventions that are believed necessary to achieve optimal levels of folic acid intake: folic acid fortification of foods and the use of supplements. The issues regarding fortification of foods with folic acid are interesting and complex but the bottom line is that in 1996 the Food and Drug Administration (FDA) established regulations that beginning January 1, 1998 cereal grain products produced in the United States, which are labeled as "enriched," be fortified with 1.4 milligrams of synthetic folic acid per kilogram of grain product. Accusations have been made that the policy decisions that led to this level of fortification, which was not considered to be optimal by some, represent "public health malpractice." Others believe that the current levels are adequate and are having the desired effect of reducing the prevalence of NTDs. While the evidence is clear that there has been a significant reduction in the prevalence of NTD pregnancies in the US population following fortification (Figure 1) folic acid intake for the average woman, based on the current level of fortification, is estimated to be well below the recommended daily intake of 400 micrograms.

The implementation of the policy for food fortification was followed by a decline in the occurrence of NTDs. While it is not known what proportion of NTDs are folic acid preventable (estimates have ranged from 40% to 80+% -- and this is likely to be related to population differences in baseline prevalence) the current level of fortification in the US is not optimal. I agree with the argument that policy should be implemented to achieve a fortification level that is approximately twice the current level. This is necessary to increase the proportion of women in the population who have intakes in the recommended range of 400 micrograms per day

**State of the Nations on Fortification: Canada and Chile now fortify grain products at higher levels than does the U.S., and have seen large decreases in NTDs. Other industrialized nations, e.g. Australia and the U.K, are still debating whether to fortify at all.**

Source: Marberly and Stanley, Mandatory fortification of flour with folic acid: an overdue public health opportunity, MJA 2005; 183 (7): 342-343

*See **Folic acid**, page 6*

## GET YOUR HOT LINKS HERE!

You may have noticed a change in News@TPHTC. We are working to make the newsletter more useful to you by including hyperlinks to sources and additional material so that you can easily pursue articles of interest in more depth. If you are reading this in the print version, you may find it convenient to refer to our online edition, where the links are always "hot:" *http://www.txphtrainingcenter.org/newsletters.htm*

# The Incredible Invisible Public Health Sector

There is a certain malaise among the public health community. As Dr. Bernard Turnock pointed out in his keynote speech to the TPHTC Summer Institute, the conventional wisdom has it that the public health sector is in rapid decline. Dr. Turnock illustrates, however, that the truth is somewhat different: as a nation in 2000 we spent almost 60% more per capita in constant dollar terms on governmental public health efforts than we did in 1990, and we have 11% more workers at all governmental levels addressing the health of the public. These data belie the notion of a fading profession. There is perhaps a deeper sense in which the public health sector has become invisible – and it is a cause for celebration. The traditional foundations of public health are no longer questioned policy choices, but are now functional requirements for all communities. While new challenges are always more complex and difficult problems, we face each crisis by building on our past successes.

The 20th century was an exciting period in terms of health trends. Nearly three decades of lifespan were added to the American population. The infant mortality rate in 2000 was just 6% of what it was in 1900. The age-adjusted mortality rate in 2003 was less than 58% of the rate a century before. In effect, a child born in 2000 could expect to live almost another whole lifetime compared to his counterpart in 1900.

Much of that fundamental improvement originated, not with the medical advances that tickle the media and dazzle the folks at home, but with changes in our living environments that are of a much more pedestrian nature. The litany of that change over the century is almost endless. Improvements in housing stock built in the second half of the century largely – but not entirely – eliminated overcrowded tenement conditions in cities that bred disease and death. Mass vaccination programs reduced childhood illnesses and helped drive some diseases from the face of the earth. Automobiles now cosset the rider in airbags in the event of impact. The prevalence of smoking, while still unacceptable, is but a fraction of what it once was. We fortify grains with folic acid so that children will be born without devastating physical deficits (cf. Dr. Lowell Sever's opinion piece in this issue.) We have invested in processing plants that provide clean, safe water and in sewage collection and facilities that treat … well, you know what they treat. In mythological terms the god of health should be, not Aesculapius or even Hygeia, but a master plumber. The fellow – or woman – from Plumbers' Local 286 may not be the dashing figure of imagination and myth, but he gets the health job done.

Many of these developments have been a "come along" to rising standards of living made possible by phenomenal economic growth. A society has to be able to afford the housing, sewage systems, clean air and clean water that represent and reflect our "standard of living." These represent real social costs, but they never appear in the national accounts under "public health."

In other areas, Public Health was the midwife at the birth of key developments. The academic and practice public health communities collaborated to study populations and discovered important physical, social, and behavioral factors that put people at risk. We worked together to implement programs to attenuate that risk. We developed and implemented the programs that have convinced the vast majority of Americans that cigarettes are, as they were called long ago, coffin nails. Now the social pressure to reduce exposure to second hand smoke is building, We have turned the handle and drained the swamp. And in the process we have taught and turned over to others the responsibility of handle-turner and drainer-of-swamps. Others fortify the grain and still others bake the bread that helps ensure a healthy birth. All of this is under the watchful eye of field public health practitioners who do quality control on the processes and look for the next handle to be turned. It is in this sense that public health is absorbed into the infrastructure, the social institutions, and the culture. This is exactly as it should be.

***Carol Galeener, PhD***
*The University of Texas School of Public Health, Program Manager TPHTC*

***Jeff Talbert, PhD***
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## Summer Institute *continued from page 1*

Challenges in Public Health Today;" and Dr. Bob Howard of Howard and Associates in Atlanta who explored crisis communications with the haunting query: "Getting it Right in Prime Time: Your Fifteen Minutes of Fame …Will it be a time for you to be Famous or Infamous?" Dr. Scott Lillibridge, Director of the CBPHP, kicked off the Managing Public Health Emergencies track with a presentation highlighting the methods employed to address public health emergencies.

Several faculty and speakers have made their presentations available for online viewing. You may want to check out these links in the online edition.

***James, Burdine, PhD,***
***Ken McLeroy, PhD***
*Community Capacity for Health Improvement*

***Mary desVignes-Kendrick, MD,***
***Garry McDaniel, Ed. D.***
*Public Health Leadership in Pandemic Flu Disaster Response*

***Floron C. Faries, Jr. DVM, MS***
*Potential Occurrences and Emergency Management of Foreign and Emerging Animal Diseases*

***Robert Kaman, JD, PhD***
*Public Health and The Law*

***Scott R. Lillibridge, M.D***
*Train Together to Respond Together*

***Christine Markham, PhD,***
***Susan Tortolero, PhD***
*Intro to Intervention Mapping (1)*
*Intro to Intervention Mapping (2)*

***Bernard J. Turnock, MD, MPH***
*Top 10 Reasons Why We Face Challenges in Public Health Today*

If you use any of these materials in articles or presentations, please make the appropriate attribution of the source.

***-Carol Galeener, PhD***
*The University of Texas School of Public Health, Program Manager TPHTC*

## ADDICTION AND ABUSE UPDATE:

# Substance abuse trends in Texas…

For a number of years The Gulf Coast Addiction Technology Transfer Center (See: *GCATTC*) has studied issues related to the use of illicit substances and the abuse of legal products in the State of Texas. In the latest GCATTC semiannual report chronicling substance abuse trends in Texas, Dr. Jane C. Maxwell of the University of Texas at Austin School of Social Work reports that while there are a few indicators pointing to a slight moderating trend in the use of some drugs, on the whole the picture remains grim, and some aspects are even alarming. (For the full report see: *June, 2006*) This topical Update summarizes highlights from that report and other sources.

### Coke is still King...

"Cocaine is the primary illicit drug for which Texans enter treatment and it is a major problem on the border with Mexico," advises Dr. Maxwell.

Nation-wide, powder cocaine and its smokable form, "crack," swelled from an almost immeasurable percentage lifetime use in the mid-60's to 14.2% of the population in 2004. While indicators of cocaine use state-wide are relatively stable or only slightly increasing, it has grown substantially in lethal effect over the past decade. In 2004 it was a factor in the deaths of almost 700 Texans, more than three times the annual rate of a dozen years before.

The Trend Report notes that lifetime use of all forms of cocaine reported by Texas students moderated from 9% in 1998 to 8% in 2004. These data, however, are not entirely cause for celebration. Detracting from this positive development, cocaine-related calls to the Texas Poison Control Center more than doubled over the same time period. Perhaps equally dismaying, CDC's 2005 Youth Risk Behavior Surveillance (YRBS) data indicate that 6% of all Texas high school students reported having used powder or crack cocaine *in the prior month* (For the full report see: *YRBS*).

The data may also mask another serious issue – a shift in geographic and ethnic usage patterns. Notable is a high rate of growth of cocaine use in Texas border counties. In 2004, by Grade 12, 23% of border county students report having had some lifetime experience with cocaine; "only" 10% of their counterparts in non-border counties report ever having used cocaine.

Nor are the geographic trend and concomitant shift in the ethnicity of users isolated to the school age population. From 1987 to 2005, Hispanics admitted to DSHS-sponsored treatment programs for powder cocaine addiction more than doubled as a percentage of the treated population, to just over 50%. Within the Hispanic segment 60% of admissions are inhalant users. This may be a harbinger of worse things to come as some users in this subpopulation progress toward more "hard-core" cocaine products and riskier routes of administration. Trends in crack cocaine admissions may be an early indicator of that process: Black admissions for treatment of crack addiction dropped from 75% of admissions in 1998 to less than half in 2005 while White and Hispanic admissions correspondingly increased. The rate for Hispanic admissions for crack cocaine addiction more than trebled to 17 % during this time period.

Powder cocaine is coming over the southern border in significant amounts for destinations within Texas and beyond. Throughout the state, cocaine in various forms is widely available. Crack is manufactured from powder cocaine and distributed locally virtually everywhere in the state. These local operations generally involve small processors and solo distributors. Prices in some locations are dropping as lower-cost, higher-profit margin methamphetamine and its derivative product "Ice" compete against cocaine for the drug abuser's dollar. "Meth" has become, for example, the drug of choice in Tyler, where powder cocaine commands the highest street price among Texas cities surveyed.

For more information on cocaine, its origins, effects, and treatment options, Ctrl/click to follow the link: *http://www.nida.nih.gov/PDF/RRCocain.pdf*

### Speed kills...

"Speed," a low purity form of the stimulant methamphetamine was first seen in the San Diego area and in Hawaii decades ago. It migrated into other urban Southwest areas where it became widely available to the abusing community. It is now prevalent in other regions of the U.S. as well. Currently methamphetamine is more of a problem in the northern half of Texas, but its popularity is increasing everywhere in the state. Most meth trafficked in Texas now is the much purer "Ice" produced in Mexico. Ice is quickly replacing the speed which was produced in the local "mom and pop" labs that had used pseudoephedrine which is now more difficult to acquire.

"Ice," (aka "Crystal" or "Tina") is a clear form of high purity methamphetamine that is smoked. It is increasingly the methamphetamine variant of choice for Texas drug users. In 2005 for the first time smoking surpassed injection as the prime route of administration among those admitted to DSHS-sponsored treatment for meth abuse. A measure of the size of the emerging public health challenge is that the 2005 YRBS reports 8% lifetime use of methamphetamine report-

*See **Addiction**, page 4*

**Test your "Abuse and Addiction IQ"**

You can test your "Abuse and Addiction IQ" by answering the questions below. Correct responses may be found on page 4. More information may be found in the materials referenced in the Addiction and Abuse Update article on this page.

- Texans abuse alcohol more than any other drug.
- "Crack babies" are a lost generation.
- Cocaine-related deaths in Texas are at an all-time low.
- Methamphetamine is an "upper."
- Meth costs less to produce than cocaine.
- You cannot become addicted by inhaling heroin.

## Addiction *continued from page 3*

ed by Texas students, a sobering statistic considering the addictive potential of the drug.

Drug abusers are attracted to meth for several reasons -- the high is relatively quick to achieve and lasts longer than with cocaine. However, this immediate "rush" takes a severe toll on users. As Dr. Nora Volkow, Director of the National Institute on Drug Abuse noted recently in testimony to Congress: "As the most potent of the stimulant drugs, amphetamines elicit more dopamine release than other drugs -- three times more than cocaine. This extra sense of pleasure is followed by a 'crash' that often leads to increased abuse of the drug and eventually to difficulty in feeling any pleasure at all." (For Dr. Volkow's full testimony which includes status and outlook of treatment options, Ctrl/ Click: *http://www.nida.nih.gov/PDF/RRCocain.pdf*.)

### There's a reason it's called "rotgut"...

More Texans have problems with alcohol than with any other drug. Alcohol is cited as the primary drug of abuse in roughly one-quarter of all admissions to public treatment programs in Texas. Further, alcohol figures in more arrests for drug-related incidents than any other substance. As reported by the Texas DPS, in 2004 DWI and public intoxication arrests combined occurred at a rate of 1% of population. Despite this surprisingly high rate, the public intoxication arrest rate has actually been trending down over the prior ten year period, although it is unclear if this is a real secular trend or an artifact of relaxed enforcement policy.

The profile of the client admitted to a public program for alcohol has changed considerably since 1988. Then, most clients were male (82%), White (63%), and they averaged 35 years of age. In 2005, the profile was more likely to include women (37%), less likely to be White (57%), and slightly older (37 years). The proportion of those admitted with a secondary drug problem increased from 33% to 47%. A key factor in the increase is the 23% of clients who abuse cocaine as well as alcohol because the combination delivers an intensified euphoria.

The trend of high school students who report binge drinking (five or more drinks at one time) as a norm has been decreasing since 2000, although it remains at an unacceptably high level with an alarming 30% of high school students reporting having binged in the past month (2005 YRBS).

### Lean, mean, and high...

Ecstasy indicators are all up in Texas. The drug has escaped from the White rave scene into the general population, and is growing within the Black and Hispanic communities. Codeine-based cough syrups ("Lean") and marijuana remain substances of abuse, with mixed indicators of trend.

On the brighter side, despite ready availability and dropping prices, heroin use indicators are constant or perhaps have even dipped slightly. In Houston heroin use was down by 2004, but treatment demand has increased with the influx of significant numbers of people displaced by Hurricane Katrina. As Dr. Maxwell points out, though, in locations where shooting galleries have disappeared, as in the Montopolis section of Austin, it is because many of the old line hardcore heroin users are either dead, in prison, or have moved on to other locations as the result of policing pressure. As with cocaine the death data tells a story of the natural course of the disease. In 2004 there were 415 deaths in Texas with a mention of heroin, narcotics, or another opiate, marking a 10-year high.

### Answers to "Abuse and Addiction IQ"

- Texans abuse alcohol more than any other drug. True.
- "Crack babies" are a lost generation. False – while children who were exposed to crack may show some deficits later, they are not automatically doomed to severe physical and mental problems.
- Cocaine-related deaths in Texas are at an all-time low. False – just the opposite, cocaine-related deaths are at all all-time high.
- Methamphetamine is an "upper." True.
- Meth costs less to produce than cocaine. True.
- You cannot become addicted by inhaling heroin. False – this is a common but mistaken notion "on the street."

### Tools for Rapid Assessment of Substance Abuse

Reprinted with permission from *The Center for Excellence in Epidemiology*, a Center within the Gulf Coast Addiction Technology Transfer Center at the University of Texas at Austin School of Social Work.

- **SAMHSA's Multiple Indicator Analysis: Using Secondary Data to Analyze Illicit Drug Use** "Multiple Indicator Analysis" (MIA) is a method that can be used by planners and administrators to assess the nature and extent of substance abuse in selected geographic areas. Using information from different data sources the method offers a relatively quick and inexpensive way to examine questions and issues critical to planners policy makers and service providers at State county city and community levels.
- **Assessing Drug Abuse Within and Across Communities** To help communities understand their local drug abuse problems NIDA developed this guidebook to assist in the development of a drug abuse epidemiologic surveillance systems to assess local drug abuse patterns and trends. This model can be used by states counties cities and communities. It is based on the work of NIDA's Community Epidemiology Work Group (CEWG) a national surveillance network composed of researchers from around the country that has been meeting biannually for more than 20 years to monitor drug use and abuse trends.
- **Barefoot Epidemiologist** This paper by John Newmeyer was written in 1991 and is still an excellent introduction to needs assessment.

*The webpage for the Center for Excellence in Epidemiology is also convenient site for links to: National Surveys; Examples of Local Epidemiological reports; State Substance Abuse data; Recent Publications; and Additional Data Sources.*

## PUBLIC HEALTH RESOURCES

**EDUCATION AND TRAINING**

Epidemic Intelligence Service (EIS): Two-year, post-graduate program of service and on-the-job training for health professionals interested in the practice of epidemiology. For more information go to *http://www.cdc.gov/eis/index.htm*

Public Health Exercise Toolkit Guide. This HSEEP-consistent exercise toolkit is a guide for local public health agency staff who develop, implement and evaluate emergency drills and exercises. It is also useful when facilitating public health aspects of multi-agency emergency exercises. The complete exercise kit can be found at *http://www.nursing.hs.columbia.edu/research/ResCenters/chphsr/pdf/PublicHealthBooklet_060803.pdf*

**NEWS**

**APHA Says Nation's Public Health Work Force Faces Staffing and Resource Crises in the Wake of Hurricane Katrina and 9/11.** The American Public Health Association (APHA) calls for immediate action to avert critical shortages of public health workers who respond to public health threats and emergencies. See *http://www.apha.org/news/press/2006/0806_katrinacrisis.htm*.

**America's Obesity Epidemic Getting Worse. According to a new report from Trust for America's Health** (TFAH), adult obesity rates continued to rise in 31 states over the past year while government policy efforts have consistently failed to provide viable solutions to the growing obesity crisis. Visit *http://www.rwjf.org/newsroom/newsreleasesdetail.jsp?id=10428*.

**SOPHE Launches Health Educator Ethics Survey.** The Society of Public Health Education (SOPHE) Ethics Committee is seeking insights related to ethical health education practice. See: *http://www.zoomerang.com/recipient/survey-intro.zgi?p=WEB225GGKS6X6C* for more information.

**Most Americans Do Not Know When or How Often To Get Cancer Screening Tests.** While most Americans know that mammograms, pap smears, and colonoscopies are screening exams for cancer, the majority of Americans do not know the age at which initiation of these tests is recommended, according to the latest brief from the Health Information National Trends Survey (HINTS). Visit *http://www.nih.gov/news/pr/aug2006/nci-03.htm*

**NHLBI offers complete guide to physical activity for a healthy heart.** The National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health (NIH) has developed a new publication, "Your Guide to Physical Activity and Your Heart." This guide presents comprehensive information on the impact of physical activity on your heart, as well as the power of physical activity to keep you healthy overall. For more info: *http://www.nih.gov/news/pr/aug2006/nhlbi-08.htm*

**UPCOMING CONFERENCES**

**Local and State**

The Texas Public Health Association and the Wichita Falls-Wichita County Public Health District Presents:

**Emerging Issues in Public Health Conference-October 12-13**, Wichita Falls, Multi-purpose Events Center. For more information call, Terri Pali at 512-336-2520 or Jan Flores at 940-761-7804.

The Texas Public Health Association and the Waco-McLennan County Public Health District Presents: **The Road to Excellence- Building Healthier Communities-October 26-27**, Waco. For more information or questions call 254-750-5486 or visit *www.mclennanpublichealth.org*

**NATIONAL CONFERENCES**

**American Public Health Association 134th Annual Meeting and Exposition**, Nov. 4-8, 2006, Boston, MA *http://www.apha.org/meetings/*

**Society for Public Health Education 57th Annual Meeting**, November 2-4, 2006, Boston, MA. *http://sophe.org/content/57th_Preliminary_Program.pdf*

**Understanding and Reducing Disparities in Health: Behavioral and Social Science Research Contributions**, October 23-24, 2006, Bethesda, MD. *http://obssr.od.nih.gov/HealthDisparities/index.html*

### Facts from the 2005 National Profile of Local Health Departments

***LHD Leadership***

- Nearly half of LHD top executives are in their 50s
- 32% of LHD top executives have been in their current positions for ten years or more
- 58% of LHD top executives hold graduate level degrees
- 51% of LHD top executives hold medical or nursing degrees

***LHD Workforce***

- 40% of the LHD workforce is comprised of employees in three occupational categories: nurses; environmental health specialists; and managers and directors.
- 59% of the LHDs have an emergency preparedness coordinator
- Approximately 20% of the LHD employees will be eligible for retirement within five years.

*Source: NACCHO 2005 National Profile of Local Health Departments*

**The Texas Public Health Training Center (TPHTC)** is a workforce development consortium of the University of Texas School of Public Health at Houston; the University of North Texas Health Science Center, School of Public Health and the Texas A&M University System Health Science Center, School of Rural Public Health. TPHTC is a formal partner with the UT Center for Biosecurity and Public Health Preparedness. Principal funding for the Center provided through a grant from the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (USDHHS).

***www.txphtrainingcenter.org***

**Folic Acid** *continued from page 1*

without having to rely on the use of supplements. Given the current levels of fortification, however, an important public health message is that all women capable of becoming pregnant should take either folic acid or multivitamins containing folic acid. This is essential if we are to achieve a goal of preventing all folic acid-preventable birth defects.

***--Lowell E. Sever, PhD***

Dr. Sever is Professor of Epidemiology and Disease Control at the UT School of Public Health. In 2005 Dr. Sever was a Fulbright Scholar in Ukraine, working with the medical and public health communities on birth defects epidemiology and prevention policies. Earlier in his career, while at CDC, Dr. Sever received a U.S. Public Health Service Special Recognition Award: 'In recognition of outstanding leadership and scientific contributions to the prevention of birth defects and developing disabilities." At the UT School of Public Health, he received the John P. McGovern Outstanding Teacher Award in 2000 and 2006.

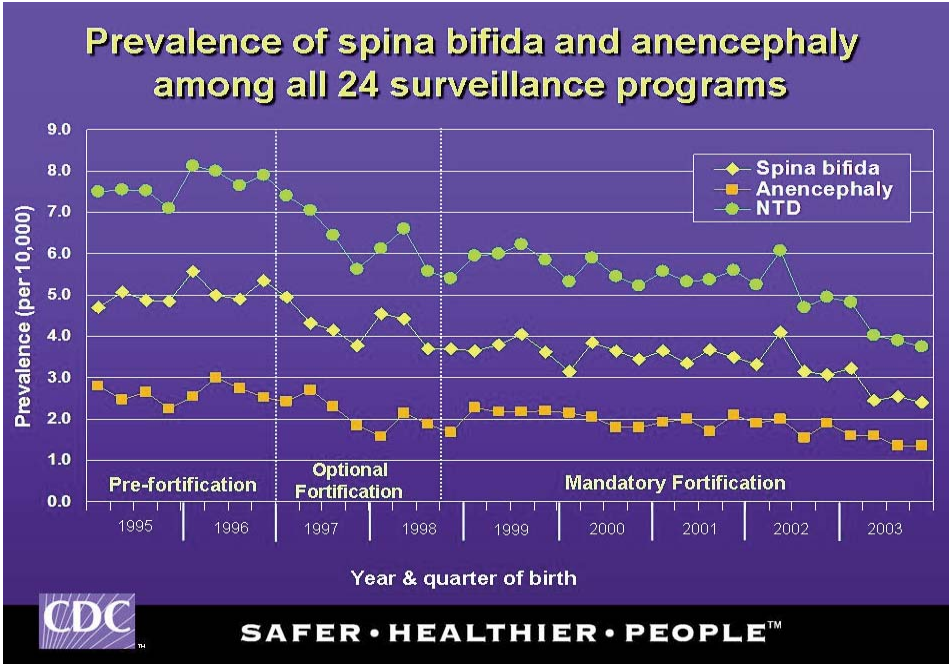


*Figure 1*

**Folic acid and birth defects surveillance:**

- National Birth Defects Prevention Network: *http://www.nbdpn.org/index.html*
- Guidelines for Conducting Birth Defects Surveillance (L. E. Sever (ed.), June 2004): http://nbdpn.org/current/resources/sgm/NBDPN_Guidelines.pdf
- Texas Folic Acid Surveillance Survey (updated 04/2004): *http://www.nbdpn.org/FolicAcidSurveys/2004TX1_WHS.html*

## The Librarian's Corner

**"The fact that an opinion has been widely held is no evidence whatever that it is not utterly absurd."**

*-Bertrand Russell*

Evidence-based (EB) practice is all the rage these days, at least for librarians! Unfortunately, virtually all of the new products are for EB medicine with little thought given to the needs of the public health practitioner. In this issue, I will discuss some (free!) resources that can help provide an evidence based approach to your public health practice.

The definition of evidence-based public health (EBPH) that I prefer is one from Neal Kohatsu in which he defined evidence based public health as "the process of integrating science-based interventions with community preferences to improve the health of populations."[1] He brings together the concepts of community preferences (i.e. community values), scientific evidence, and the mission of public health for a more holistic approach, similar to the definition for evidence-based health care.

However, as noted by Brownson *et al.*[2], little intervention research is effectively disseminated. Consequently, research does not get translated into practice.

One way public health practitioners can be certain they are following best practices and current guidelines is by using Web-based resources that demonstrate EBPH practices. The Centers for Disease Control and Prevention (CDC) and the Agency for Healthcare Research and Quality (AHRQ) publish guidelines and best practices. The EPPI-Centre, in England, has created a database of health promotion research which is composed of citations to articles on health promotion topics; but the full text is not available through the database.

Of course, one must mention the Cochrane Library. This large database is available to search for free. A search for reviews on "smoking cessation" pulls approximately 50 articles. There is a "plain language" summary along with a more detailed abstract. Unfortunately, a subscription is required to read the full review, but the abstracts are very detailed, often providing some of the statistical analysis as well as the author's conclusions.

One way to find these resources is to visit my web site on evidence-based public health resources: *http://www.sph.uth.tmc.edu/library/default.asp?id=2909*. I've tried to collect the best of the best EBPH sites. I've also linked to sites that provide additional information (but look at those *after* you've investigated my site.) Of course, if you have any questions, please feel free to contact me: *Helena.M.VonVille@uth.tmc.edu*.

1. Kohatsu ND, Robinson JG, Torner JC. Evidence-based public health: An evolving concept. Am J Prev Med. 2004 Dec;27(5):417-21.

2. Brownson RC, Kreuter MW, Arrington BA, True WR. Translating scientific discoveries into public health action: How can schools of public health move us forward? Public Health Rep. 2006 JAN-FEB;121(1):97-103.

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