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# Commentary on the Emerging *Guide to Community Preventive Services* from a Health Promotion Perspective

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It probably could not have happened much sooner: the need for a systematically evidence-based guide to community preventive services was widely felt, but without the methodologic developments in community research, program evaluation, and data synthesis of recent years, it might have been a futile exercise in attempting to replicate the Cochrane-style reviews of randomized clinical trials. Without the explosion of community studies of health promotion and disease prevention programs in recent years, the pool of data would have been too shallow to produce much depth of understanding or breadth of generalizability. The timing of the exercise reported in the pages of this issue of the *American Journal of Preventive Medicine* could not have been much better from these developmental perspectives on the state of the art and science of community and population health. The field of public health has had time to mature beyond the communicable-disease paradigm. It has built substantially on its successes and its lessons for community and population health, but now it integrates with increasing utility the social and behavioral science theories and methods needed to encompass a wider and more entangled web of health determinants and interventions. So we approach the request to comment on this guide with the sense of adventure that comes with being on the shore of a new exploration, a new thrust on the frontiers of knowledge and health development.

## The Framework

What strikes the public health educator and health promotion eye first about the framework adopted by the Task Force on Community Preventive Services (Task Force), as reported in Truman et al.,<sup>1</sup> is the shift of behavior from its previous position of risk factors on which we must intervene directly to the position of

“intermediate outcome.” Rather than putting behavior in the role of “determinant,” the Task Force has placed it alongside other intermediate outcomes in the “causal pathway between a determinant and the final health outcome.” This is consistent with the social determinants theories and ecologic approaches that have emerged in health promotion internationally with the *Healthy People* initiative in the United States; the Ottawa Charter; and various Canadian, European, and World Health Organization initiatives in health promotion and population health.

In a similar vein, the Task Force has given prominence to non-health effects worthy of special attention in their review of studies. We take these to be, broadly speaking, quality-of-life, social, and environmental effects beyond the intended health outcomes. This is a refreshing departure from the single-minded focus other professions and sectors have come to expect of the health professions and sciences.

## The Audience(s)

We were pleased to see the considerable emphasis placed on the intended practitioner and policymaker audiences for the guide, the prospects for effective dissemination to these groups, and the subsequent adoption and effective implementation of the recommendations. Effective translation, however, is no easy task. Each of the steps in the application process needs to be anticipated and guided as carefully and thoughtfully as the review process that distilled the evidence. The extent to which the methods and results of the *Guide to Community Preventive Services* (the *Guide*) redirect and refocus prevention research will be an important indicator of the success of the dissemination process. An early marker will be the language framing requests for research and demonstration proposals (RFPs and RFAs) coming from the governmental, philanthropic, and private sectors.

## The Exclusions and Inclusions

Zaza et al.<sup>2</sup> presents the logic, criteria, and evidence for including topics in the first phases of the *Guide* development. The first two criteria in the “structured priority-setting exercise” of the Task Force align comfortably

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**Table 1.** Policy and program planning options

	More important	Less important
More changeable	Highest Priority for program focus	Low priority except to demonstrate change for political purpose
Less changeable	Priority for innovative program with evaluation essential	No intervention program

for us with the criteria we have recommended, since the early 1970s, for setting priorities for interventions in health education and health promotion planning.<sup>3</sup> When placed in a 2 X 2 table with high and low values on importance (burden of disease, injury, impairment, or exposure) and changeability (preventability, in this case), these criteria suggest policy and program planning options, illustrated by Table 1.

In the upper left cell containing more important and more preventable topics, the implications are for high-priority, universal programs. For those in the lower right cell the implications are equally clear for low-priority, no intervention programs. In the other two cells, however, ambivalences arise. If the issue is important, but the evidence is poor for preventability, the topic cannot be ignored by practitioners and policy makers because of their importance, regardless of the protestations of evidence-based task forces. The policy and planning implication is for innovation in programs, combined with a strong, budgeted commitment to evaluation and research. For those topics falling into the upper right cell, the implication would seem to be to cut back on programs because their importance cannot be defended, but political and cultural expediencies and advantages might dictate continuing and even initiating such programs in some circumstances. The evidence-based lens of the Task Force might preclude the subtleties of these political and cultural considerations. That might be as it must be within the scope of the *Guide*. Experience tells us that the closer the *Guide* comes to application at the community level, the greater the need to use it with various political and cultural lenses.

Among the types of interventions largely excluded from review in the *Guide* are national and international policies and "clinical interventions used exclusively by an individual practitioner for an individual patient in an office setting." These exclusions make obvious sense for a guide with "Community" and "Preventive" as the operative terms in its title. Yet, what communities might need to do is sometimes precluded by preemptive legislation at the state level (a favored tactic of the tobacco industry, for example, in heading off the many local brush fires they could not hope to contain). What communities might try to do often depends on support from state and national levels. The vertical connections will need to be made, if not in the *Guide*, then in the field by those who use it.

As for the clinical exclusions, these are covered in the

*Guide to Clinical Preventive Services*, which provided the inspiration for this *Guide*. Inevitably, these clinical interventions by practitioners with individual patients will have to be integrated or harmonized with community programs because they are done *in* the community. Much (if not most) of the best data on evaluation will emanate from here because this is where randomized controlled trials are most commonly done. We would also anticipate that the Task Force will feel increasing pressure not to draw such a hard line between their inclusion of primary and secondary prevention and their exclusion of tertiary prevention. If the latter precludes coverage of the growing evidence on self-care and self-management interventions related to chronic conditions, these might be expected to muscle their way onto the list as the U.S. population continues to age.<sup>4</sup>

### The Methods Applied

The Green and Kreuter article,<sup>5</sup> covering the Task Force's adopted methods, honestly and even-handedly addresses some of the most contentious issues in weighing what types of evidence, standards, and criteria constitute relevant and adequate evidence for community interventions. The Task Force showed insight by agreeing to give similar weight to smaller numbers of studies with better execution than to larger numbers of studies with "less suitable design or weaker execution." Clearly, this gives alternative methodologies a hearing, but the debate will still hinge on what "less suitable" means, and to whom, for what purposes. Nevertheless, it is around the issue of what constitutes relevant and adequate evidence that the *Guide* will face its most severe criticisms from academic defenders of emerging and alternative methodologies.

At the same time, those responsible for education and training in public health research and practice will find a rich gem in the Data Abstraction Form used in the methodologic process (see the Appendix to the article by Zaza et al. in this supplement). In the hands of a competent instructor, this data abstraction form would constitute a very pragmatic way to help students see how complex factors influence judgements made about the quality of community interventions. The suitability criteria allow for the studies to collect either individual or ecologic data. The gap that we predict will emerge from the reviews is not so much with ecologic data, but with ecologic interventions. Much of what is

labeled “community” health promotion intervention remains directed at individuals, whether through mass media, institutional programs in classrooms, small work groups or church groups, or individual counseling in clinical and non-clinical settings.<sup>6</sup> This gives rise to the need to make the subtle distinction between community interventions, where the goal is to make small changes across a population, and interventions in a community, where the intent is to achieve a profound change within a specific subpopulation.<sup>7</sup> In either case, identifying and weighing the influence of the contextual variables inherent in the community setting remain a major methodologic challenge.

Recognizing this challenge and the reality that population-based interventions are “dynamic areas undergoing rapid development,” the Task Force anticipates “evolving methods to keep up with developments in the field.” These reassuring words apply as well for the variability across population groups, which the first review applied to vaccine-preventable diseases illustrates. The key variable in community studies may prove to be variability itself, especially as we seek to generalize from community studies carried out in selected places, populations, and times.

### A Final Caveat and Recommendation

In limiting the database to the English-language literature, the Task Force acknowledges that this “could result in missing some applicable information.” This may be perceived as an understatement by those whose work on community health interventions appears in other languages. Some of the best Canadian work on community health promotion has been published in French; some of the best European work is in Dutch, German, and Scandinavian; and even in the United States and points south, an emerging literature in Spanish should be anticipated. Fortunately, much of the best work from these places is also available in English.

Understandably, the Task Force’s methods are limited by the reality that the time frame for the published studies tends to extend to the modest time frames of most grants. This means that many of the outcomes measured, especially from a health promotion perspec-

tive, will have had too little time to accumulate from the many little intermediate changes necessary to have an impact on more complex social conditions, lifestyles, and chronic conditions. One way to address this limitation is to construct a continuous, interactive system for gathering information about prevention research and practice as part of the infrastructure of the public health system. In the aggregate, this information would constitute a much-needed prevention knowledge base, which if deployed over the Internet would be accessible to users worldwide. The construction of such a system would be a natural next step, continuing the rich science-to-practice tradition honored by the men and women who have brought the *Guide* to fruition.

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Disclaimer: Although current employees of the Centers for Disease Control and Prevention, the lead agency in developing the *Guide to Community Preventive Services*, neither author has had a direct hand in developing or executing this initiative as employees or consultants.

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