

RESEARCH ON ALCOHOL HEALTH DISPARITIES

Release Date: October 4, 2001

RFA: RFA-AA-02-002

National Institute on Alcohol Abuse and Alcoholism

Letter of Intent Receipt Date: December 28, 2001

Application Receipt Date: January 17, 2002

THIS RFA USES "MODULAR GRANT" AND "JUST-IN-TIME" CONCEPTS. MODULAR INSTRUCTIONS MUST BE USED FOR RESEARCH GRANT APPLICATIONS UP TO \$250,000 PER YEAR. MODULAR BUDGET INSTRUCTIONS ARE PROVIDED IN SECTION C OF THE PHS 398 (REVISION 5/2001) AVAILABLE AT <http://grants.nih.gov/grants/funding/phs398/phs398.html>.

PURPOSE

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) seeks applications to support research to identify, characterize, and reduce through prevention, treatment, and health services interventions alcohol-related health disparities in American ethnic and cultural populations and their subpopulations. Target populations are intended to include but not be limited to persons of African heritage, Hispanic/Latino culture, Native Americans/Alaskan Natives, Asian Americans, and Native Hawaiian and Pacific Island Populations.

The purpose of this Request for Applications (RFA) is to address major aspects of alcohol-related health disparities through research on epidemiology, pathogenesis, metabolism, neuroscience, and prevention, treatment and health services. The NIAAA encourages multidisciplinary and interdisciplinary research in collaboration with clinicians and scientists at minority serving institutions.

HEALTHY PEOPLE 2010

The Public Health Service (PHS) is committed to achieving the health promotion and disease prevention objectives of "Healthy People 2010," a PHS led national activity for setting priority areas. This RFA is related to one or more of the priority areas. Potential applicants may obtain a copy of "Healthy People 2010" at <http://www.health.gov/healthypeople/>.

ELIGIBILITY REQUIREMENTS

Applications may be submitted by domestic and foreign, for-profit and non-profit organizations, public and private, such as universities, colleges, hospitals, laboratories, units of State and local governments, and eligible agencies of the Federal Government. Faith-based organizations are eligible to apply for these grants. Racial/ethnic minority individuals, women, and persons with disabilities are encouraged to apply as principal investigators.

MECHANISM OF SUPPORT

This RFA will support research through the National Institutes of Health (NIH) Research Project grant (R01) and Exploratory/Development grant (R21) award mechanisms, as well as an Education Project grant (R25). Responsibility for the planning, direction, and execution of the proposed project will be solely that of the applicant. The total project period for a research project grant (R01) application submitted in response to this RFA may not exceed 5 years. Exploratory/developmental grants (R21) are limited to 3 years for up to \$100,000 per year for direct costs. Education Project grants (R25) are also limited to three years but have a maximum of \$250,000 per year in total costs (i.e., includes indirect costs which may not exceed 8% of

direct costs). This RFA is a one-time solicitation.

FUNDS AVAILABLE

The NIAAA intends to commit approximately \$3 million in FY 2002 to fund up to 12 new and/or competitive continuation grant applications in response to this RFA. Because the nature and scope of the research proposed might vary, it is anticipated that the size of awards will also vary. Although the financial plans of the NIAAA provide support for this program, awards pursuant to this RFA are contingent upon the availability of funds and the receipt of a sufficient number of meritorious applications. At this time, it is not known if this RFA will be reissued. Applicants should request funds to attend an annual meeting on alcohol-related health disparities to be arranged by the NIAAA.

BACKGROUND

Alcohol consumption is associated with a wide range of adverse health and social consequences, both acute (e.g., traffic deaths, other injuries) and chronic (e.g., alcohol dependence, liver damage, stroke, cancers of the mouth and esophagus). The scope and variety of these problems are attributable to differences in the amount, duration, and patterns of alcohol consumption; differences in genetic vulnerability to particular alcohol-related consequences; and differences in economic, social, and other environmental factors. Ethnic and cultural disparities in alcohol-related problems vary with the problem under consideration and are of pressing public health concern. Alcohol-related death rates (for all categories of alcohol-related mortality combined) are higher among Blacks than whites. Recent research indicates that cirrhosis death rates are higher among white men and women of Hispanic origin than among non-Hispanic black and white Americans. Alcohol-related traffic deaths are many times more frequent (per 100,000 population) among American Indians or Alaska Natives than among other minority populations. The incidence of fetal alcohol syndrome (FAS) appears to be several times higher in some African American and American Indian communities than in the general population. Research also reveals that although African American teenagers typically drink less than their white or Hispanic counterparts, their mortality from cirrhosis is substantially higher as they approach middle age. Other adverse health consequences associated with alcohol consumption such as cirrhosis, alcoholic liver disease, HIV/AIDS, cardiomyopathy, pancreatitis, and alcohol-related sleep disorders are also more prevalent in some minority populations. Finally, increases in risky drinking behavior (i.e., drinking and driving) have been reported among Hispanics. Since ethnic minority groups have differing genetic backgrounds, it is possible that some of the disparities in disease incidence and prevalence are due to differences in genetic predisposition. This is suggested for example, by reports that some groups exhibit greater susceptibility to the same total dose of alcohol, or exhibit similar degrees of pathogenesis with reduced exposure. Furthermore, genetic and biological factors may interact with behavioral and cultural factors to manifest health disparities.

The continuing development of scientific knowledge about the incidence, prevalence, etiology, and course of alcohol-related problems among minority populations and their subpopulations is, thus, of fundamental importance. The nation's increasing cultural and ethnic diversity adds to the complexity of this task, but also highlights opportunities for significant new insights about the causes and consequences of alcohol-related health disparities. Epidemiological research increases understanding of the nature and scope of alcohol-related health disparities and helps define new hypotheses for subsequent research. Disparities seen in organ damage, pregnancy outcome, and the other sequelae of alcohol consumption may be related to biological and/or environmental factors, as well as their complex interactions. Thus,

while genetic differences in alcohol metabolism or the central nervous system reactivity to alcohol may be important risk factors, so also are differences in patterns of drinking and access to health care. Research on the interplay of ethnicity, culture, and environment as they affect consumption patterns, quantity, and type of alcohol (e.g., wine, beer, malt liquor, distilled spirits) might, likewise, provide valuable information about the underlying causes of the differential alcohol-related pathology found in some minority populations and groups.

With respect to prevention, there is a critical need to identify and evaluate the efficacy and effectiveness of interventions to prevent alcohol abuse, dependence, and related problems among racial and ethnic minority populations. First, there is a need to evaluate in various minority groups the efficacy of interventions that have proved effective in studies of the general population or populations that are predominantly white. It is also important to determine the applicability to minority populations of naturally occurring prevention strategies that have proved effective through natural experiments that focus on cross sections of the population as a whole. Moreover, investigators need to test the assumption that interventions (both treatment and prevention) tailored to the health needs and problems of minority populations and/or delivered in a culturally competent fashion will be more effective than generic interventions. Furthermore, research is needed to identify the social and cultural factors that may influence motivation for treatment, adherence to treatment, and treatment outcomes. Such research may involve tests of interventions that have been reported as effective for the population as a whole but not for particular racial/ethnic subgroups, or exploit the alcohol-related data that have not been exploited in existing data sets. Important considerations in undertaking minority-focused intervention research include the theoretical justification for potential new interventions, samples of sufficient size to draw conclusions about effects on that particular group, and possible comparisons with other groups or with a sample of the general population.

STUDIES ARE NEEDED TO ADDRESS HEALTH DISPARITIES INCLUDING BUT NOT LIMITED TO THE FOLLOWING AREAS OF RESEARCH:

1) Epidemiology

- Increase knowledge about the incidence, prevalence, etiology, course, and natural history of alcohol-related problems, including alcohol abuse and alcohol dependence, among minority populations.
- Examine the relationship of alcohol consumption and alcohol abuse and dependence to other psychiatric disorders and conditions among racial/ethnic populations.
- Examine the relationship of alcohol consumption to the development, course and outcomes of physical illnesses including heart disease, cancer, liver disease and HIV/AIDS in racial/ethnic subgroups.
- Explore patterns of alcohol consumption (e.g., frequency, quantity, duration, beverage type) which may increase or decrease risk for particular alcohol-related problems among minority populations.
- Increase knowledge about risk and protective factors (personal, environmental and genetic) for alcohol-related problems among minority populations.
- Explore the effects of assimilation into the adopted environment on the initiation of alcohol use and the development of alcohol-related problems (including alcohol abuse and alcohol dependence) among minority immigrant groups.
- Elucidate factors associated with the initiation of and abstinence from drinking among adolescents and young adults in specific minority groups.
- Determine the relationship between alcohol consumption during pregnancy and the high incidence of infant mortality, stillbirths, and Sudden Infant Death Syndrome (SIDS) among some minority groups.
- Examine the role of alcohol consumption in intentional and unintentional injury and death (including homicide, suicide, and

traffic crashes) among minority populations.

2) Adverse Pregnancy and Infant Health Outcomes

- Based on minority populations, develop and test research- and theoretically-based interventions for addressing the educability of FAS and ARND children ages 3-8; considering neurocognitive, neurobehavioral assessment studies, neuro-imaging studies and animal model research.

3) Biomedical, Behavioral and Neuroscience

- Longitudinal follow-up studies in minority populations to determine the relationship between sociocultural and genetic factors in the initiation of drinking and development of alcohol-related problems.

- Studies on the effects of sleep loss on behavioral symptoms, sympathetic nervous system activity, and cellular immune function in African Americans with alcohol dependence.

- Studies on whether ethnic differences in alcohol-induced sleep disturbances contribute to the variation in sympathetic nervous system and immunological effects of alcohol.

- Studies on the interactive effects of alcohol and HIV on progression of central nervous system disease in minority populations.

- Determine how known racial differences in alcohol-metabolizing enzymes interact with sociocultural variables to influence alcohol consumption patterns and adverse health outcomes in minority populations.

- Identify mechanisms where alcohol contributes to development of diseases in minority groups with disparities in survival rates, especially associated with Hepatitis C, AIDS, and opportunistic infectious diseases.

- Develop biomedical interventions that address those mechanisms.

4) Prevention Interventions

- Conduct pre-intervention studies to determine those aspects of minority drinking environments, patterns, and problems as well as community norms, values and unique cultural factors that are likely to influence the outcomes of preventive intervention efforts.

- Replicate in minority communities preventive interventions based in schools, colleges, and families that have proved to be effective in general populations.

- Assess effects on minority populations of integrated community-based environmental strategies to reduce alcohol-related crashes, violence, and sales to minors.

- Determine effects on minorities of laws and regulations that set BAC limits, mandate driver's license revocation or increase the price of alcoholic beverages through increased taxes.

- Design and test new interventions for alcohol problems that have been virtually untouched by preventive interventions including worksite-related alcohol problems, early onset of alcohol consumption in elementary school children, and alcohol-related domestic, bar, and gang violence.

- Conduct additional studies of interventions to prevent Fetal Alcohol Syndrome (FAS) and other alcohol-related birth defects among high-risk minority populations, taking into account cultural barriers to prevention and cultural facilitators.

- Assess effects of laws, sanctions, and their enforcement designed to decrease driving under the influence (DUI) and its consequences, with specific emphasis on high-risk minority communities.

- Implement and test mass communication and media advocacy targeted toward minorities and involving appropriate cultural symbols and community leaders.

- Conduct secondary analyses of existing large prevention-outcome data sets having unanalyzed data on minority respondents.

- Elucidate the impact of alcohol use and abuse on HIV/AIDS prevention efforts among minority populations and develop culturally relevant interventions for primary and secondary prevention of HIV infection among alcohol abusers in ethnic minority communities.

5) Treatment

- Assess the relative efficacy of established treatments for alcohol abuse and dependence in different minority groups.
- Develop and test behavioral/psychosocial therapies tailored to the needs of specific minority populations and subpopulations suffering from alcohol dependence/abuse and a comorbid psychiatric disorder.
- Evaluate the efficacy of pharmacological treatments in various minority populations, using medications alone or in combinations, or in conjunction with behavioral/psychosocial interventions.
- Determine the validity of assessment instruments for minority populations.
- Identify social and cultural factors that mediate and moderate motivation for treatment, adherence to treatment, and treatment outcomes.
- Develop behavioral techniques to improve retention of minority clients in alcoholism treatment.
- Develop and test effective interventions for minority adolescents with alcohol problems.
- Determine the effects of alcoholism treatment among minorities who are both alcohol abuse/dependent and HIV positive. Possible outcome measurements include alcohol consumption, adherence to HIV treatment regimens, and HIV risk behaviors.

6) Health Services Research

- Effectiveness studies of how improved treatment outcomes can be achieved in applied clinical settings.
- Studies of access to alcohol treatment for minority populations, including barriers to treatment, insurance coverage and other financial limitations, and availability to culturally sensitive behavioral treatments.
- Studies of disparities in the costs, cost-effectiveness, cost-benefits, or cost-offsets of treatment for minority clients or for treatment clinics operating in minority communities.
- Studies of the processes that lead individuals to seek treatment, including individual decision-making; informal social influences from family and friends; and institutional pressures from employers, the legal system, or social welfare agencies.

7) Science Education and Health Professionals Education Initiative

- Develop and evaluate science education programs for middle high school students in minority communities.
- Train physicians and other health care providers to implement effective evidence-based protocols for: detecting alcohol-related problems among minority populations; conducting office-based, primary care setting, and community clinic based interventions (including brief therapy and pharmacotherapy); and referring minority patients for additional treatment when indicated

INCLUSION OF WOMEN AND MINORITIES IN RESEARCH INVOLVING HUMAN SUBJECTS

It is the policy of the NIH that women and members of minority groups and their sub-populations must be included in all NIH-supported biomedical and behavioral research projects involving human subjects,

unless a clear and compelling rationale and justification are provided indicating that inclusion is inappropriate with respect to the health of the subjects or the purpose of the research. This policy results from the NIH Revitalization Act of 1993 (Section 492B of Public Law 103-43).

All investigators proposing research involving human subjects should read the UPDATED "NIH Guidelines for Inclusion of Women and Minorities as Subjects in Clinical Research," published in the NIH Guide for Grants and Contracts on August 2, 2000 (<http://grants.nih.gov/grants/guide/notice-files/NOT-OD-00-048.html>); a complete copy of the updated Guidelines are available at http://grants.nih.gov/grants/funding/women_min/guidelines_update.htm: The revisions relate to NIH defined Phase III clinical trials and require: a) all applications or proposals and/or protocols to provide a description of plans to conduct analyses, as appropriate, to address differences by sex/gender and/or racial/ethnic groups, including subgroups if applicable; and b) all investigators to report accrual, and to conduct and report analyses, as appropriate, by sex/gender and/or racial/ethnic group differences.

INCLUSION OF CHILDREN AS PARTICIPANTS IN RESEARCH INVOLVING HUMAN SUBJECTS

It is the policy of NIH that children (i.e., individuals under the age of 21) must be included in all human subjects research, conducted or supported by the NIH, unless there are scientific and ethical reasons not to include them. This policy applies to all initial (Type 1) applications submitted for receipt dates after October 1, 1998.

All investigators proposing research involving human subjects should read the "NIH Policy and Guidelines on the Inclusion of Children as Participants in Research Involving Human Subjects" that was published in the NIH Guide for Grants and Contracts, March 6, 1998, and is available at the following URL address: <http://grants.nih.gov/grants/guide/notice-files/not98-024.html>.

Investigators also may obtain copies of these policies from the program staff listed under INQUIRIES. Program staff may also provide additional relevant information concerning the policy.

REQUIRED EDUCATION ON THE PROTECTION OF HUMAN SUBJECT PARTICIPANTS

NIH policy requires education on the protection of human subject participants for all investigators submitting NIH proposals for research involving human subjects. This policy announcement is found in the NIH Guide for Grants and Contracts Announcement dated June 5, 2000, at the following website: <http://grants.nih.gov/grants/guide/notice-files/NOT-OD-00-039.html>.

DATA AND SAFETY MONITORING PLAN ;

As of the October 2000 receipt date, applicants must supply a general description of the Data and Safety Monitoring Plan for ALL clinical trials; this must be included in the application <http://grants.nih.gov/grants/guide/notice-files/NOT-OD-00-038.html>. The degree of monitoring should be commensurate with risk. NIH Policy for Data and Safety Monitoring requires establishment of formal Data and Safety Monitoring Boards for multi-site clinical trials involving interventions that entail potential risk to the participants. The absence of this information will negatively affect your priority score.

URLS IN NIH GRANT APPLICATIONS OR APPENDICES

All applications and proposals for NIH funding must be self-contained within specified page limitations. Unless otherwise specified in an NIH solicitation, internet addresses (URLs) should not be used to

provide information necessary to the review because reviewers are under no obligation to view the Internet sites. Reviewers are cautioned that their anonymity may be compromised when they directly access an Internet site.

PUBLIC ACCESS TO RESEARCH DATA THROUGH THE FREEDOM OF INFORMATION ACT

The Office of Management and Budget (OMB) Circular A-110 has been revised to provide public access to research data through the Freedom of Information Act (FOIA) under some circumstances. Data that are (1) first produced in a project that is supported in whole or in part with Federal funds and (2) cited publicly and officially by a Federal agency in support of an action that has the force and effect of law (i.e., a regulation) may be accessed through FOIA. It is important for applicants to understand the basic scope of this amendment. NIH has provided guidance at:

http://grants.nih.gov/grants/policy/a110/a110_guidance_dec1999.htm.

Applicants may wish to place data collected under this RFA in a public archive, which can provide protections for the data and manage the distribution for an indefinite period of time. If so, the application should include a description of the archiving plan in the study design and include information about this in the budget justification section of the application. In addition, applicants should think about how to structure informed consent statements and other human subjects procedures given the potential for wider use of data collected under this award.

LETTER OF INTENT

Prospective applicants are asked to submit a letter of intent that includes a descriptive title of the proposed research, the name, address, and telephone number of the Principal Investigator, the identities of other key personnel and participating institutions, and the number and title of the RFA in response to which the application may be submitted. Although a letter of intent is not required, is not binding, and does not enter into the review of a subsequent application, the information that it contains allows NIAAA staff to estimate the potential review workload and plan the review.

The letter of intent is to be sent December 28, 2001.

APPLICATION PROCEDURES

The PHS 398 research grant application instructions and forms (rev. 5/2001) at <http://grants.nih.gov/grants/funding/phs398/phs398.html> are to be used in applying for these grants and will be accepted at the standard application deadlines (<http://grants.nih.gov/grants/dates.htm>) as indicated in the application kit. This version of the PHS 398 is available in an interactive format. For further assistance contact GrantsInfo, Telephone 301/435-0714, Email: GrantsInfo@nih.gov.

SPECIFIC INSTRUCTIONS FOR MODULAR GRANT APPLICATIONS

The modular grant concept establishes specific modules in which direct costs may be requested as well as a maximum level for requested budgets. Only limited budgetary information is required under this approach. The just-in-time concept allows applicants to submit certain information only when there is a possibility for an award. It is anticipated that these changes will reduce the administrative burden for the applicants, reviewers and NIH staff. The research grant application form PHS 398 (rev. 5/2001) at <http://grants.nih.gov/grants/funding/phs398/phs398.html> is to be used in applying for these grants, with modular budget instructions provided in Section C of the application instructions.

The RFA label available in the PHS 398 (rev. 5/2001) application form

must be affixed to the bottom of the face page of the application. Type the RFA number on the label. Failure to use this label could result in delayed processing of the application such that it may not reach the review committee in time for review. In addition, the RFA title and number must be typed on line 2 of the face page of the application form and the YES box must be marked. The RFA label is also available at: <http://grants.nih.gov/grants/funding/phs398/label-bk.pdf>.

Submit a signed, typewritten original of the application, including the Checklist, and three signed, photocopies, in one package to:

CENTER FOR SCIENTIFIC REVIEW
NATIONAL INSTITUTES OF HEALTH
6701 ROCKLEDGE DRIVE, ROOM 1040, MSC 7710
BETHESDA, MD 20892-7710
BETHESDA, MD 20817 (for express/courier service)

At the time of submission, two additional copies of the application must be sent to:

Extramural Project Review Branch
RFA-AA-02-002
National Institute on Alcohol Abuse and Alcoholism
6000 Executive Blvd, Suite 409, MSC 7003
Bethesda, MD 20892-7003
Rockville, MD 20852 (for express/courier service)

Applications must be received by the application receipt date listed in the heading of this RFA. If an application is received after that date, it will be returned to the applicant without review.

The Center for Scientific Review (CSR) will not accept any application in response to this RFA that is essentially the same as one currently pending initial review, unless the applicant withdraws the pending application. The CSR will not accept any application that is essentially the same as one already reviewed. This does not preclude the submission of substantial revisions of applications already reviewed, but such applications must include an introduction addressing the previous critique.

REVIEW CONSIDERATIONS

Upon receipt, applications will be reviewed for completeness by the CSR and responsiveness by NIAAA. Incomplete and/or non-responsive applications will be returned to the applicant without further consideration. If the application is not responsive to the RFA, CSR staff may contact the applicant to determine whether to return the application to the applicant or submit it for review in competition with unsolicited applications at the next review cycle.

Applications that are complete and responsive to the RFA will be evaluated for scientific and technical merit by an appropriate peer review group convened by the NIAAA in accordance with the review criteria stated below. As part of the initial merit review, all applications will receive a written critique and undergo a process in which only those applications deemed to have the highest scientific merit, generally the top half of the applications under review, will be discussed, assigned a priority score, and receive a second level review by the NIAAA National Advisory Council.

Review Criteria

The goals of NIH-supported research are to advance our understanding of biological systems, improve the control of disease, and enhance health. In the written comments reviewers will be asked to discuss the following aspects of the application in order to judge the likelihood that the proposed research will have a substantial impact on the

pursuit of these goals. Each of these criteria will be addressed and considered in assigning the overall score, weighting them as appropriate for each application. Note that the application does not need to be strong in all categories to be judged likely to have major scientific impact and thus deserve a high priority score. For example, an investigator may propose to carry out important work that by its nature is not innovative but is essential to move a field forward.

(1) Significance: Does this study address an important problem? If the aims of the application are achieved, how will scientific knowledge be advanced? What will be the effect of these studies on the concepts or methods that drive this field?

(2) Approach: Are the conceptual framework, design, methods, and analyses adequately developed, well-integrated, and appropriate to the aims of the project? Does the applicant acknowledge potential problem areas and consider alternative tactics?

(3) Innovation: Does the project employ novel concepts, approaches or method? Are the aims original and innovative? Does the project challenge existing paradigms or develop new methodologies or technologies?

(4) Investigator: Is the investigator appropriately trained and well suited to carry out this work? Is the work proposed appropriate to the experience level of the principal investigator and other researchers (if any)?

(5) Environment: Does the scientific environment in which the work will be done contribute to the probability of success? Do the proposed experiments take advantage of unique features of the scientific environment or employ useful collaborative arrangements? Is there evidence of institutional support?

In addition to the above criteria, in accordance with NIH policy, all applications will also be reviewed with respect to the following:

- o The adequacy of plans to include both genders, minorities and their subgroups, and children as appropriate for the scientific goals of the research. Plans for the recruitment and retention of subjects will also be evaluated.
- o The reasonableness of the proposed budget and duration in relation to the proposed research.
- o The adequacy of the proposed protection for humans, animals or the environment, to the extent they may be adversely affected by the project proposed in the application.
- o The adequacy of the proposed plan to share data, if appropriate.)

Schedule

Letter of Intent Receipt Date: December 28, 2001
Application Receipt Date: January 17, 2002
Peer Review Date: March-April 2002
Council Review: May 2002
Earliest Anticipated Start Date: July 1, 2002

AWARD CRITERIA

Award criteria that will be used to make award decisions include:

- o scientific merit (as determined by peer review)
- o availability of funds
- o programmatic priorities.

INQUIRIES

Inquiries concerning this RFA are encouraged. The opportunity to clarify any issues or answer questions from potential applicants is welcome.

Direct inquiries regarding programmatic issues to:

Thomas Gentry, Ph.D.
Office of Collaborative Research
National Institute on Alcohol Abuse and Alcoholism
6000 Executive Boulevard MSC 7003, Suite 302
Bethesda, MD 20892-7003
Rockville, MD 20852 (for express mail/courier)
Telephone: (301) 443-6009
FAX: (301) 480-2358
Email: tgentry@mail.nih.gov

Direct inquiries regarding fiscal matters to:

Judy Fox Simons
Grants Management Branch
National Institute on Alcohol Abuse and Alcoholism
Willco Building, Suite 505
6000 executive Blvd. (MSC-7003)
Bethesda, MD 20892-7003
(For express mail use:
Rockville, MD 20852)
Telephone: (301) 443-2434
Email: jsimons@willco.niaaa.nih.gov

AUTHORITY AND REGULATIONS

This program is described in the Catalog of Federal Domestic Assistance No. 93.273. Awards are made under authorization of Sections 301 and 405 of the Public Health Service Act as amended (42 USC 241 and 284) and administered under NIH grants policies and Federal Regulations 42 CFR 52 and 45 CFR Parts 74 and 92. This program is not subject to the intergovernmental review requirements of Executive Order 12372 or Health Systems Agency review.

The PHS strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of all tobacco products. In addition, Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care, or early childhood development services are provided to children. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

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National Institutes of Health (NIH)
9000 Rockville Pike
Bethesda, Maryland 20892