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CDC's 60th Anniversary: Director's Perspective --- David Satcher, M.D., Ph.D., 1993--1998

One of the important legacies at CDC is continuity of leadership. Like runners in a relay race, each CDC leader passes the baton of leadership smoothly to the next without disrupting the important programs necessary to protect the health of the nation. This perspective provides reflections on three aspects of CDC during the mid-1990s: first, continuing momentum in several important programs; second, strengthening CDC's infrastructure in terms of resources, programs, and organization; and third, responding to the emerging epidemic of overweight and obesity and the need to encourage healthy lifestyle choices.

Continuing Momentum: Childhood Vaccinations, HIV/AIDS, and Breast and Cervical Cancer Screening

One of the most important challenges and opportunities facing CDC in the mid-1990s was to increase vaccination rates among children by the age of 2 years. In 1991, only slightly more than 50% of children were fully vaccinated by this age; the goal was to dramatically increase that rate to 90% by the end of the decade, and the 3-year goal was set at 75% (1). CDC was charged by Congress with implementing the Vaccines for Children program, a novel vaccine-financing approach introduced in 1994 that included access to government-funded vaccines through private-sector providers in addition to traditional public clinics. CDC's partnerships with the Congress of National Black Churches; the Women, Infants, and Children program; the National Council of La Raza; and the National Council of Churches USA were particularly important in achieving vaccination goals. Likewise, CDC worked with foundations, including The Annie E. Casey Foundation, the Robert Wood Johnson Foundation, and the Task Force for Child Survival and Development to develop vaccine registries so that health-care providers would know the vaccination status of children who were being treated in their offices. In cities where vaccination rates were especially low, such as Detroit, Michigan (29%), CDC's partnership with the mayor's office was critical.

Because the human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) epidemic was continuing to advance, maintaining and improving efforts in surveillance and education was important to prevent or reduce the spread of the disease, as was optimizing the application of treatments such as AZT (i.e., azidothymidine or zidovudine) to new populations (2). CDC educated health-care providers about the importance of testing pregnant females for HIV and initiating treatment to reduce the transmission of HIV from mother to child. The dramatic decline in mother-to-child transmission of HIV is one of the most significant success stories in the battle against HIV/AIDS. In addition, informing providers and patients about available treatments and coordinating this with education on the importance of early detection and

prevention was critical. CDC brought eight different internal HIV/AIDS programs together with other sexually transmitted disease (STD) and tuberculosis (TB) programs to create a new center, the National Center for HIV, STD, and TB Prevention, under the leadership of Dr. Helene Gayle.

Also during this period, CDC gathered the results of several programs evaluating the use of needle- and syringe-exchange programs that had been funded nationwide. The findings provided strong evidence that needle-exchange programs could reduce the spread of HIV in the drug-injecting population without increasing drug use.

In the area of cancer control, CDC worked with states to implement the National Breast and Cervical Cancer Early Detection Program, increasing coverage from 18 states to all 50 states, the District of Columbia, six territories, and 15 American Indian/Alaska Native tribes and tribal organizations. This program has resulted in a dramatic increase in screening for breast and cervical cancer and in early detection and intervention (3).

Strengthening CDC's Infrastructure

Continuing to strengthen the infrastructure of CDC was essential; the agency faced the challenges of emerging infectious diseases, environmental health problems, and changing public health approaches to injury prevention, violence prevention, and lifestyle modification. New, more sensitive methods were developed to screen for environmental toxins in blood, urine, air, and soil. The National Center for Injury Prevention and Control funded eight centers of excellence for research in injury and violence prevention. Several new programs, including the Global Health Odyssey, were implemented to document the role of CDC in the history of public health in the United States and the world. In addition, the Office of Genetics and Disease Prevention (now the National Office of Public Health Genomics) was established at CDC to examine the relationship between the results of the Human Genome Project and the health of persons in the United States, as well as to assess related ethical and social health issues. The CDC Foundation, an independent, nonprofit organization approved by Congress in 1992, was instituted by appointing an outstanding board of directors and by recruiting an exceptional foundation director, Charlie Stokes. In its first 10 years, the foundation raised more than \$100 million to support global and other CDC efforts.

As the work of public health professionals and CDC began to require increasingly innovative program management, the agency considered the need for a new training program in addition to the successful Public Health Advisors program, which had made great strides in tracking and controlling infectious diseases. As a result, the Public Health Prevention Service (PHPS) program was developed to prepare persons with master of public health degrees to be leaders in community program development. Skills in data collection and management, communication, and organization at the community level were critical requirements for participants in this program. To this day, the mission of PHPS is "to contribute to the development of a highly trained public health workforce of prevention specialists with public health experience and the management and leadership skills necessary to promote the health of populations at the global, federal, state, and local levels (4)."

CDC also recognized the need to expand beyond an excellent clinical resource that the U.S. Department of Health and Human Services (DHHS) had been providing for clinicians over the years, the *Guide to Clinical Preventive Services*, with a parallel tool for communities. Thus, CDC developed the *Guide to Community Preventive Services (The Community Guide)*, beginning with the appointment of an exceptional board of advisors. Funding was provided for research to evaluate existing community-prevention programs, with *The Community Guide* representing the culmination of formal evaluations.

Although CDC was working toward strengthening its internal infrastructure, improving the health of all persons required public trust. The Tuskegee Study, infamous to most persons working in public health, was recognized as a major barrier to developing the trust needed to improve the health of the country; the mid-

1990s provided an opportunity to formally address this longstanding issue. The study, an experiment started by the U.S. Public Health Service (PHS) in 1932 and ended in 1972, involved monitoring the health effects of syphilis on 400 black men in Tuskegee, Alabama. The men were not treated for the disease, even after the development of penicillin in the 1940s, an effective treatment for syphilis. Responsibility for the Tuskegee Study was transferred to CDC in 1959; after much debate, the study was discontinued in 1972, with CDC assuming responsibility for providing lifetime health and medical benefits to survivors and families.

CDC established a national commission to revisit the Tuskegee Study and describe its nature and impact on participants, PHS, and the nation. This commission, led by Dr. Vanessa Gamble, a physician anthropologist from the University of Wisconsin, produced an in-depth report. With the help of the secretary of health and human services, CDC presented the report to the president of the United States, who agreed that a presidential apology was appropriate. On May 16, 1997, in the East Room of the White House, with survivors and families present or watching by satellite in Tuskegee, the president presented the nation's apology for the Tuskegee Study (5). More importantly, he outlined strategies for ensuring that such a study would never occur in the country again. He noted that the Tuskegee Study had helped lead to clear guidelines for informed consent from medical research subjects and required compliance training for persons receiving federal support for research involving humans. He also announced a commitment to develop a Tuskegee center for training researchers in bioethics. The Tuskegee University National Center for Bioethics in Research & Health Care was established in 1999.

Responding to an Emerging Epidemic: Overweight and Obesity

In addition to strengthening CDC's response to existing public health problems, each CDC director is faced with new challenges. During the 1990s, the new challenge did not stem from an infectious disease but from lifestyle and environmental factors. The 1990s saw the rise of the overweight and obesity epidemic.

CDC's Behavioral Risk Factor Surveillance System (BRFSS) survey documented this problem. In 1990, no state in the country had an obesity rate of $>15\%$ (with obesity defined as a body mass index [BMI], measured in kilograms per meters squared, of ≥ 30). By 1995, more than half of the states had an obesity rate of 15% - 19% , and by 2000, 22 states had obesity rates of $>20\%$. By 2005, 17 states had obesity rates of $\geq 25\%$, with two thirds of the nation being classified as overweight (BMI ≥ 25) and one third being classified as obese.

Led by the National Center for Chronic Disease Prevention and Health Promotion, CDC responded to this health threat by producing *Physical Activity and Health: A Report of the Surgeon General* in 1996 (6), the same year that CDC celebrated its 50th anniversary and the Olympics took place in Atlanta, Georgia, the location of CDC headquarters. The report pointed to the dramatic decline in school-based physical activity in the United States. The percentage of children participating in physical education from kindergarten through 12th grade had declined from 45% in 1991 to 25% in 1995 (6). A *Healthy People 2000* objective called for increasing the percentage of children and adolescents in first through 12th grades who participated in daily school physical education, but the trend was moving in the opposite direction. Likewise, although *Healthy People 2000* objective 1.5 was to reduce to no more than 15% the proportion of persons aged 6 years and older with no engagement in leisure-time physical activity, by 1994, the overall proportion of adults reporting no leisure-time physical activity was 29.4% (1).

The Surgeon General's 1996 report highlighted the benefits of regular physical activity in greatly reducing the risk for dying from coronary heart disease and the risk for developing diabetes, colon cancer, and related diseases. Physical activity also was credited with enhancing mental health and producing healthy muscles, bones, and joints and with helping to maintain function and preserve independence in older adults.

Although data clearly indicated that school-based physical activity opportunities had declined dramatically in the country, the epidemiologic causes of the overweight and obesity epidemics were unclear (6).

Subsequent studies indicated that few persons in the United States were following the nutrition guidelines recommended by the U.S. Department of Agriculture and DHHS. In addition, two factors emerged as likely contributors to the epidemic. First, calories were more readily available and cheaper, emerging in the form of fast foods with more fat and sugar. Second, technology had reduced both the need and the incentive to be physically active, and aspects of the built environment were becoming less conducive to physical activity. For example, to encourage children to become more physically active, CDC implemented the Kids Walk to School program; however, the absence of sidewalks and unfavorable location of certain schools mitigated its success.

In conjunction with CDC's 50th anniversary celebration, a Director's Challenge was issued for CDC employees to become more physically active and consume more fruits and vegetables. Incentives such as an extra half hour for lunch were implemented, and cafeteria foods such as salads and grilled items were made readily available. Supervisors were asked to support the program, and a spirit of friendly competition developed throughout the organization. By the end of 1996, approximately 65% of the 7,000 CDC employees reported being physically active on a regular basis.

CDC's efforts continued in the battle against obesity, leading to the inclusion of seven obesity objectives in *Healthy People 2010* (7). My own efforts continued as I moved on from CDC to become Surgeon General and DHHS Assistant Secretary for Health, and in 2001 issued *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity* (8). The report, written with extensive technical support from CDC, detailed the nature of the epidemic and made specific recommendations for action, in the home and community, schools, and the workplace and among health-care providers and members of the media.

Continuing the Legacy

Since the 1990s, continuity of leadership at CDC has maintained momentum in infectious-disease prevention and control and in the immunization program. Vaccination levels are at an all-time high. Racial/ethnic disparities in vaccination coverage have been eliminated (9), and new vaccines have been introduced that have drastically reduced certain childhood diseases in the United States, such as disease from *Haemophilus influenzae* b, previously the leading cause of childhood meningitis in the United States (10).

The epidemic of overweight and obesity continues to be a major challenge for the nation and the world, and controlling it will require global cooperation. CDC and the nation must remain committed to a vigorous program of education and lifestyle enhancement with appropriate incentives in the home, the community, schools, and work sites. Support for this attack on obesity and related chronic diseases must be consistent, persistent, and sustained. Success will require continuity of CDC leadership to sustain needed research and translate it into effective action.

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In commemoration of CDC's 60th Anniversary, MMWR is departing from its usual report format. This is the fifth in a series of occasional commentaries by directors of CDC. The directors were invited to give their personal perspectives on the key public health achievements and challenges that occurred during their tenures.

David Satcher, M.D., Ph.D., was director of CDC during 1993--1998. Before his CDC tenure, Dr. Satcher was president of Meharry Medical College in Nashville, Tennessee. He left CDC in 1998 to become the 16th Surgeon General of the United States and simultaneously held the position of Assistant Secretary for Health in the Department of Health and Human Services. In 2002, Dr. Satcher returned to Atlanta, Georgia, where he has served at Morehouse School of Medicine as director of the National Center for Primary Care (2002--2004) and then as president of the medical school (2004--2006). He now serves as director of the Center of Excellence on Health Disparities at Morehouse School of Medicine.

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