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Congress of the United States

Washington, DC 20515

September 11, 2000

HIV Prevention in the New Millennium

A Congressional Briefing on the Draft CDC HIV Prevention Strategic Plan
Thursday, September 14th

Dear Colleague:

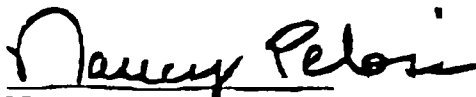
Each year over 40,000 Americans are newly infected with HIV, and it is estimated that half of those infections occur in young people under age 25. In addition, the HIV/AIDS epidemic is moving increasingly into new populations. People of color now represent a majority of new AIDS cases and the proportion of new AIDS cases among women has grown from 11% in 1990 to 23% today.

The changing nature of the HIV/AIDS epidemic, along with the continuing impact of HIV/AIDS in traditionally affected communities, has created new challenges for our HIV prevention efforts. We invite you and your staff to attend a briefing, sponsored by the CDC and AIDS Action, on the draft 5-year HIV Prevention Strategic Plan that the CDC has developed in response to these challenges. The CDC has involved over 100 experts in public health, prevention science and affected communities to develop this plan which is designed to cut the number of new HIV infections by half by 2005. We believe that this important goal can be met with sufficient resources, political commitment and enhanced collaboration across all sectors (federal, state and local; public, private and non-profit).

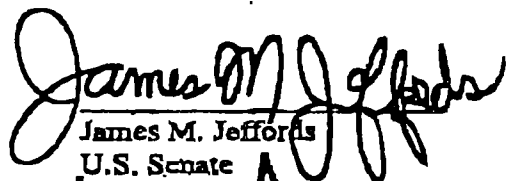
The public comment period for the draft plan began on September 11 and will run until October 23, 2000. Since many of your constituents will be participating in the public comment period, we encourage you and your staff to join us on Thursday, September 14, from 2:30-3:30 p.m. in the Capitol, Room HC-6. Copies of the draft plan and executive summary will be available at the briefing. Speakers include Representative Nancy Pelosi; Julio Abreu, Deputy Director of Government Affairs, AIDS Action; and Helene Gayle, M.D., M.P.H., Director of CDC's National Center for HIV, STD, and TB Prevention. A question and answer period will immediately follow.

For more information or to RSVP, please call Julio Abreu at AIDS Action at (202) 530-8030.

Sincerely,



Nancy Pelosi
U.S. House of Representatives



James M. Jeffords
U.S. Senate



Edward M. Kennedy
U.S. Senate



Arlen Specter
U.S. Senate



John Edward Porter
U.S. House of Representatives

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09/13/00 WED 08:53 [TX/RX NO 9216]



DvonZinkernagel@osophs.dhhs.gov (Deborah Von Zinkernagel)
09/13/2000 05:41:53 PM

Record Type: Record

To: Cheryl S. Bauerle/OPD/EOP

cc:

Subject: Public Comment Draft of the HIV Prevention Strategic Plan

Content-Type: multipart/alternative;

Dear All --

YOUR HARD WORK IS ABOUT TO GO PUBLIC!

Attached is the version of the draft HIV prevention strategic plan that will go up on CDC's website beginning Monday, September 11. The public comment period will run September 11-October 23, 2000. As you know, a series of public meetings and smaller, invitation-only meetings will be held early in the public comment period to get widespread feedback about the plan. I hope you're planning to attend at least one. Please let the contractor know as soon as possible if you plan to attend. For those outside CDC, we will pay for your travel, of course. Contact Marcia Early at 1-888-404-6558, ext. 508 to make your travel arrangements.

I will be on leave all next week. If you need anything, you can try to reach someone in our office at 404-639-8008, but we're moving, so there may be some disruption in phone service. You can always email me, and I'll get back to you when I return on September 11.

Thank you so very much for all the hard work you put into this strategic plan. IT SHOWS!

Lydia

Lydia Ogden, MA, MPP
Centers for Disease Control and Prevention
National Center for HIV, STD, and TB Prevention
1600 Clifton Road, NE (E07)
Atlanta, GA 30333
Phone: 404-639-8031, 8008
Fax: 404-639-8629
Email: lxa3@cdc.gov

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<DIV> Lydia </DIV>

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<P> Lydia Ogden, MA, MPP

 Centers for Disease Control

and Prevention
 <FONT color=#0000ff face="Century Gothic"
size=2> National Center for HIV, STD, and TB Prevention
 <FONT

DRAFT

September 2000

**Centers for Disease Control
and Prevention**

**HIV Prevention
Strategic Plan
Through 2005**

September 2000

CDC's Goals for HIV Prevention

- 1. Reduce the number of new HIV infections per year in the United States from an estimated 40,000 to 20,000 per year by 2005.**
- 2. Through voluntary counseling and testing, increase the proportion of HIV-infected people in the United States who know they are infected from the current 70% to 95% by 2005.**
- 3. Increase the proportion of HIV-infected people in the United States who are linked to appropriate care, prevention services and treatment services from the current estimated 50% to 80% by 2005.**
- 4. Reduce HIV transmission and improve HIV/AIDS care and support through partnership with resource-constrained countries.**

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CDC Is Seeking Your Comments on the Draft HIV Prevention Strategic Plan

CDC invites your comments on the comprehensiveness, clarity, coherence and viability of the draft five-year strategic plan. We are especially interested in learning about any gaps you perceive. The plan is available on CDC's website (www.cdc.gov) or through the CDC National Prevention Information Network by calling 1-800-458-5231.

If possible, organize your comments using this framework so that we may address them most easily:

- **General comments on the overall plan**
- **Specific comments on Goal 1 and its objectives and strategies**
- **Specific comments on Goal 2 and its objectives and strategies**
- **Specific comments on Goal 3 and its objectives and strategies**
- **Specific comments on Goal 4 and its objectives and strategies**
- **Comments on priorities**

Be sure to include your contact information so that we can let you know about any changes in the plan following the comment period.

Please send your comments postmarked or emailed by October 23, 2000, to:

**HIV Prevention Plan Comments
National Center for HIV, STD, and TB Prevention
Centers for Disease Control and Prevention (E07)
1600 Clifton Road NE
Atlanta, GA 30333
USA
Email address: hiv.plan.comment@cdc.gov**

Comments postmarked or emailed after October 23, 2000, cannot be considered.

Public Meetings on the Draft Strategic Plan

CDC is holding four public meetings to seek comments and input on this draft. The meetings will be held from **1:30-4:30 p.m. local time** on these dates and in these locations:

Tuesday, Sept. 19, 2000

Holiday Inn-Bay Bridge
1800 Powell Street
Emeryville, CA 94608
510-658-9300

Wednesday, Sept. 20, 2000

Red Lion
2525 West South Loop
Houston, TX 77027
713-961-3000

Thursday, Sept. 21, 2000

Congress Plaza Hotel
520 South Michigan Avenue
Chicago, IL 60605
312-427-3800

Thursday, Sept. 28, 2000

Hotel Pennsylvania
410 7th Avenue
New York, NY 10001
212-736-5000

The meetings will be open to the public, limited only by the space available. The meeting rooms each accommodate approximately 100 people.

Acknowledgments

CDC gratefully acknowledges the time, effort and expertise of the external consultants and internal CDC staff who helped craft this strategic plan. The members of the four workgroups, corresponding to the four HIV prevention goals, are listed in Appendix B, page 58.

We also recognize the guidance of the agency's Advisory Committee for HIV and STD Prevention, which was the catalyst for the development of this plan and whose members provided invaluable insights into its refinement.

Finally, we acknowledge the help of the staff of Management Assistance Corporation, who arranged meetings and travel, facilitated workgroup meetings and provided support in the development of this document.

Acronyms

AETC	AIDS Education and Training Center, funded by HRSA
AHRQ	Agency for Healthcare Research and Quality, a DHHS agency that provides information on health care outcomes, quality, cost, use and access
AIDS	Acquired Immunodeficiency Syndrome
AZT	Azidothymidine, a drug used to fight HIV disease; effective at interrupting mother-to-child HIV transmission
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention, a DHHS agency, promotes health and quality of life by preventing and controlling disease, injury and disability through partnerships throughout the nation and the world to monitor health, detect and investigate health problems, conduct applied research to enhance prevention, develop and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthful environments and provide leadership and training
CIOs	The various Centers, Institute and Offices that make up CDC
CPG	Community Planning Group, a local council that determines HIV prevention priorities for state and local health departments funded by CDC
DHHS	Department of Health and Human Services, a U.S. government entity
DOT	Directly Observed Therapy
FDA	Food and Drug Administration, a DHHS agency, assures the safety of foods and cosmetics, and the safety and efficacy of pharmaceuticals, biological products and medical devices, including HIV tests
HAART	Highly Active Anti-Retroviral Treatment, multi-drug treatment for HIV infection
HCFA	Health Care Financing Administration, a DHHS agency, administers the Medicare and Medicaid programs, which provide health insurance to America's aged, poor, disabled and indigenous populations, and the States Children's Health Insurance Program (SCHIP), all of which include people with HIV/AIDS

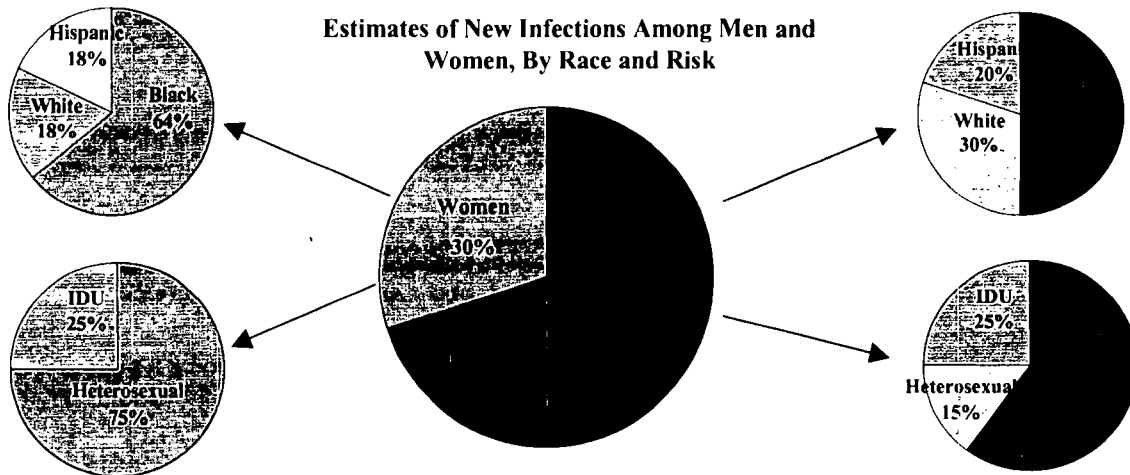
HE/RR	Health Education/Risk Reduction, an essential component of HIV prevention programs
HIV	Human Immunodeficiency Virus, the virus that causes AIDS
HRSA	Health Resources and Services Administration, a DHHS agency, provides health resources for medically underserved populations; provides services to people with AIDS through the Ryan White CARE Act programs; supports a nationwide network of community and migrant health centers, and primary care programs for the homeless and residents of public housing; builds the health care workforce, maintains the National Health Service Corps, provides AIDS training for health care providers
IDU	Injecting Drug Use, Injecting Drug User
IHS	Indian Health Service, a DHHS agency, provides services to nearly 1.5 million American Indians and Alaska Natives of 557 federally recognized tribes
MSM	Men Who Have Sex with Men
NGO	Non-Governmental Organization
NIH	National Institutes for Health, a DHHS agency, sponsors medical research on diseases like cancer, Alzheimer's, diabetes, arthritis, heart ailments and AIDS
OI	Opportunistic Infection, associated with HIV/AIDS
PCM	Prevention Case Management
SAMHSA	Substance Abuse and Mental Health Services Administration, a DHHS agency, works to improve the quality and availability of substance abuse prevention, addiction treatment and mental health services
SCHIP	States Child Health Insurance Program, administered by HCFA; provides health coverage to children, including those with HIV/AIDS, whose parents are not eligible for Medicaid
STD, STI	Sexually Transmitted Disease, Sexually Transmitted Infection
TB	Tuberculosis
VCT	Voluntary Counseling and Testing for HIV infection

Executive Summary

Because of substantial improvements in early diagnosis and care for people infected with HIV, more Americans are living with HIV than ever before. Individuals and society as a whole are benefiting from this remarkable progress. However, it does mean more opportunities for transmitting the virus and increased needs for HIV prevention. But not all those with HIV are aware of their infection. CDC estimates that 800,000-900,000 people are living with HIV in America, and as many as one third don't even know they have the virus.

And, despite tremendous successes in HIV prevention over the past decade, the number of new HIV infections each year (incidence) in the United States remains unacceptably high. Although incidence has decreased substantially from the high of 150,000 cases per year in the late 1980s, CDC estimates that some 40,000 Americans become infected with HIV every year, and this has been true since the early 1990s.

As the pie charts below show, the HIV epidemic in America is increasingly affecting communities of color – particularly young people and women. Among men, the majority of new infections, nearly 60%, continue to be among MSM (men who have sex with men). Recent evidence of resurgent unsafe behaviors and outbreaks of other sexually transmitted diseases (such as syphilis and gonorrhea) among MSM underscore the importance of sustaining and improving prevention efforts for this population.



The Centers for Disease Control and Prevention has involved over 100 experts in public health, prevention science and affected and infected communities to devise a five-year strategic

plan to cut the number of new HIV infections annually in the United States by half and address the global HIV epidemic. The plan's four goals are:

1. **Reduce the number of new HIV infections per year in the United States from an estimated 40,000 to 20,000 per year by 2005.**
2. **Through voluntary counseling and testing, increase the proportion of HIV-infected people in the United States who know they are infected from the current 70% to 95% by 2005.**
3. **Increase the proportion of HIV-infected people in the United States who are linked to appropriate care, prevention services and treatment services from the current estimated 50% to 80% by 2005.**
4. **Reduce HIV transmission and improve HIV/AIDS care and support through partnership with resource-constrained countries.**

Research consistently shows the prevention benefit of early diagnosis and ongoing care and services for people living with HIV. In addition to leading longer and healthier lives, people who receive ongoing care for HIV disease and services to address other needs, such as substance abuse, lead safer lives – they are more likely to adopt and maintain safer sexual behaviors. Thus, early diagnosis and referral into prevention services, care and treatment have important prevention functions.

Research also clearly demonstrates the benefits of community-level HIV prevention programming to prevent those at risk for HIV from becoming infected. CDC's mechanism for supporting communities in the identification of local HIV prevention priorities is called HIV prevention community planning. Community planning empowers local communities across the United States to use epidemiologic and surveillance data, behavioral science and other scientific information to make informed decisions about where and how to target resources, and is an integral part of CDC's five-year strategic plan.

Scientists at the international AIDS conference in Durban, South Africa, estimated that providing access to community-level HIV prevention or small-group interventions to all those at risk for sexual transmission of HIV in the United States would cost upwards of \$1 billion annually. Providing prevention services to all those at risk from injection drug-related HIV infection in the U.S. would cost an estimated \$423 million annually.

Researchers estimate that the discounted cost of lifetime treatment for a person with HIV now averages about \$155,000. With 40,000 people infected yearly, America faces an additional annualized cost of more than \$6 billion each and every year. ***Clearly, prevention pays.***

This five-year strategic plan for HIV prevention is visionary and ambitious, but it can be realized, with sufficient resources, political commitment and enhanced collaboration across all sectors (federal, state and local; public, private and non-profit). Level prevention funding will not equate to a stable HIV epidemic. Instead, as more and more people live longer with disease and have the opportunity to infect others, level funding could actually translate into increases in HIV infection and AIDS.

Selected Objectives and Strategies

The framework for the five-year strategic plan is *goals*, which are achieved through the fulfillment of *objectives*, which are in turn realized through *strategies*.

Goal 1: Reduce new HIV infections per year in the United States from an estimated 40,000 to 20,000 per year by 2005.

Priority Objectives	Selected Strategies
Among people living with HIV, increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission or acquisition.	1. Develop and implement community and structural interventions to reduce stigma and discrimination surrounding HIV infection. 2. Develop, implement and evaluate voluntary, peer-based HIV prevention interventions.
Among men who have sex with men, increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission or acquisition.	1. Develop, implement and evaluate evidence-based HIV prevention programs for gay men, particularly MSM of color and young MSM. 2. Work with NGOs, the private sector and others to address the negative effects on prevention of stigma and discrimination associated with sexual orientation.
Among adolescents, increase the proportion who abstain from sexual intercourse or use condoms consistently and correctly if sexually active.	1. Develop, implement and evaluate evidence-based, community-based HIV prevention programs that help adolescents delay intercourse and help them develop safer sexual practices, particularly for adolescents in high-risk situations, especially out-of-school youth, gay/lesbian/bisexual/transgender and questioning youth, youth in detention, runaway youth and youth of color. 2. Develop, implement and evaluate evidence-based comprehensive school-based HIV prevention programs that help adolescents delay intercourse and help them develop safer sexual practices, particularly for youth of color. 3. Coordinate/collaborate with SAMHSA, NIH and other partners to increase the research on effective programs that help adolescents prevent abuse of alcohol and other drugs. 4. Develop, implement and evaluate evidence-based programs for positive family communication around sexual behavior.
Among injection drug users (IDUs), increase the proportion who abstain from drug use or who use harm reduction strategies to reduce risk of HIV transmission or acquisition.	1. Collaborate with SAMHSA, NIH and other partners to develop, disseminate, implement and evaluate health education/risk reduction and harm reduction programs and counseling and testing programs targeting IDUs. 2. Work with other federal, state and local partners to increase comprehensive services to IDUs, including HIV/STD testing, drug treatment, methadone maintenance and harm reduction programs. 3. Continue to disseminate scientific evidence that needle exchange programs are effective at reducing HIV infection while not increasing drug use.

Among at-risk sexually active women (including women who have sex with women), and at-risk heterosexual men, increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission or acquisition.	1. Develop, implement and evaluate evidence-based HIV prevention programs that strengthen the capacity of women, particularly women of color, to make protective decisions. 2. Collaborate with NIH, FDA and other partners to increase the availability and acceptability of female-controlled HIV/STD prevention technology (e.g., microbicides and female condom). 3. Increase research on the effectiveness of providing HIV prevention in STD, primary care and family planning settings.
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Goal 2: Through voluntary counseling and testing, increase the proportion of HIV-infected people in the United States who know they are infected from the current 70% to 95% by 2005.

Priority Objectives	Selected Strategies
Increase the motivation of at-risk individuals to know their infection status and decrease real or perceived barriers to HIV testing.	1. Work with a broad array of partners to identify, develop, implement and evaluate strategies to address real and perceived barriers to testing, such as fears concerning stigmatization, criminalization, partner notification, violence, risk of deportation and confidentiality. 2. Study the effects of risk-denial on individual motivation to be tested and implement strategies to overcome this barrier.
Improve access to voluntary HIV counseling and testing (VCT) in high seroprevalence communities and populations at risk.	1. Increase access to anonymous and confidential testing. 2. Increase the proportion of people with conditions (STDs, TB and hepatitis C) and behaviors (unprotected sex, multiple partners) that indicate HIV risk who are offered VCT. 3. Evaluate the effectiveness of various types of partner notification programs..
Increase the number of providers who routinely offer VCT for HIV in health care settings, including antenatal settings, as well as other venues.	1. Conduct studies to determine the effects of different pre-test counseling and consent approaches on provider willingness and ability to offer VCT. 2. In collaboration with professional organizations, develop guidance on the healthcare settings and patient populations for which VCT should be the standard of care. 3. Develop and implement education and training initiatives for physicians, nurses and other health care workers.
Increase the percentage of people who know their HIV results after testing.	1. Support the use of rapid tests to provide same-day screening results. 2. Evaluate and monitor grantees' rates of client return for test results and work with grantees to increase return rates as needed. 3. Determine the effect of patient incentives and other strategies on increasing return rates.

Goal 3: Increase the proportion of HIV-infected people in the United States who are linked to appropriate care, prevention services and treatment services from an estimated 50% to 80% by 2005.

Priority Objectives	Selected Strategies
Work with public health, the private medical sector HRSA and other partners to reduce the disparities in access to prevention and care services that are experienced by communities of color and by women.	1. Collaborate with HRSA, NIH, the affected communities and other partners to develop and implement a comprehensive research agenda that identifies and addresses barriers to prevention services and access to care. 2. Promote cultural and linguistic competence in CDC-funded programs.
Work with public health, the private medical sector and other partners (e.g., SAMHSA, HRSA) to increase the percentage of people diagnosed with HIV who are successfully linked to culturally competent, science-based behavioral prevention services.	1. Assure that HIV-infected people tested in CDC-funded sites obtain a comprehensive prevention assessment and appropriate referral to prevention case management (PCM) within 3 months of learning their HIV status. 2. Collaborate with HRSA to encourage the establishment and maintenance of behavioral prevention services in public HIV/AIDS outpatient clinics. 3. Increase the capacity of health care providers to provide behavioral prevention counseling. 4. Develop a system to monitor HIV-infected patients' linkage to prevention services.
Work with public health, the private medical sector, HRSA and other partners to increase the percentage of people diagnosed with HIV who are successfully linked to care within 3 months of learning their HIV status or of being re-identified as being HIV-infected but out of care.	1. Publish guidelines for best practices for linkage from post-test counseling to medical evaluation. 2. Conduct research to determine why previously diagnosed but currently out-of-care people didn't initially access or remain in medical care and develop interventions to enhance care utilization.

Goal 4: Reduce HIV transmission and improve HIV/AIDS care and support through partnership with resource-constrained countries.

Priority Objectives	Selected Strategies
Decrease sexually transmitted HIV infections.	1. Develop and evaluate behavioral interventions to reduce the risk of acquiring or transmitting HIV and other STDs, particularly for sex workers and their clients, displaced populations, in- and out-of-school youth, those in the workplace and for other locally relevant populations. 2. Expand VCT for HIV. 3. Investigate the most effective intervention methods to address the role of STDs in HIV transmission and acquisition and to improve STD treatment services.
Develop the capacity of partners in host countries for HIV prevention and care efforts.	1. Work with partner country governments and communities to strengthen their capacity to plan, implement, evaluate and monitor HIV interventions. 2. Work with communities in partner countries to decrease HIV stigma. 3. Build partners' capacity to develop, review and implement scientific and operational research protocols according to internationally accepted bioethical precepts.
Expand and strengthen HIV/STD/TB surveillance programs.	1. Strengthen HIV sentinel surveillance programs to monitor epidemic trends. 2. Strengthen the collection and use of behavioral data. 3. Strengthen laboratory testing. 4. Promote the use of surveillance data for public health decision-making.
Improve basic scientific knowledge of HIV and the safety and efficacy of new technologies.	1. Evaluate the safety and efficacy of HIV vaccine candidates and vaginal microbicides. 2. Conduct and apply HIV virologic research, focusing on the epidemiology, ecology and evolutionary biology of HIV infection. 3. Conduct HIV vaccine and microbicide preparedness work, including the development of relevant cohorts. 4. Evaluate and apply new laboratory tests for HIV.
Decrease HIV infections from mother to child.	1. Expand access to VCT services for antenatal women. 2. Conduct research on improving biomedical and behavioral methods to interrupt mother-to-child transmission. 3. Expand access to antiretroviral drugs for HIV-infected pregnant women and their newborns. 4. Provide appropriate breastfeeding alternatives.

Increase access to improved HIV care and support.	1. Strengthen VCT programs to make critical linkages to care and support. 2. Work with communities to decrease HIV stigma. 3. Expand and strengthen programs that prevent and treat TB and other opportunistic infections. 4. Conduct and apply research on the clinical management of HIV. 5. Conduct research on the psychological and social needs of people living with HIV/AIDS and people affected by HIV/AIDS.
Decrease parenterally transmitted HIV infections.	1. Strengthen the capacity of countries to provide sufficient safe blood for transfusion. 2. Conduct and apply research on behavioral change methodologies, including targeted harm reduction programs, to prevent IDU-related transmission. 3. Strengthen the capacity of health care workers to prevent parenteral HIV infection to themselves and to their patients.

Foreword

Over the last two decades, HIV/AIDS prevention science has advanced dramatically. Mother-to-child HIV transmission has been drastically reduced, accounting for an estimated 300 to 400 perinatal HIV infections annually in recent years, thanks to widespread adoption of routine, voluntary HIV counseling and testing for pregnant women and the availability of the drug AZT to interrupt transmission from the pregnant woman to her baby. And new hope for reducing the risk of infection among men who have sex with men, injection drug users and women has been realized through strong community-level interventions, multi-faceted behavioral prevention that addresses people's ability to make healthy decisions and sustain protective behaviors.

Change has accelerated in the last 5 years, with the advent of new drug combinations to treat HIV infection, delaying the onset of AIDS and offering the hope of reducing further transmission, as infected people's viral loads are diminished and their potential infectiousness possibly reduced. But the promise of treatment advances is not without pitfalls: Research shows that optimistic attitudes about treatment may be contributing to increased risk behavior among young MSM as well as among other groups at risk for HIV infection. And, without lifelong prevention support services to help them adopt and maintain healthy behaviors, the growing number of people living longer with HIV form a wellspring of potential infection. Behavioral science continues to shed light on the best ways to motivate people to adopt and maintain safer behaviors, reducing their risk of acquiring HIV if they are seronegative or of transmitting HIV if they are already infected.

The face of the epidemic is changing as well – in addition to the groups who have been at highest risk since the beginning of the epidemic, MSM and injection drug users, other populations are also at risk. As shown in Figure 1 below, more and more people of color, and especially women

and successive waves of young people, are placing themselves in harm's way. CDC estimates that approximately 40,000 people per year are infected with HIV, a number that has remained relatively stable – **but unacceptably high** – for much of the past decade. **At this point in the epidemic, it is time for CDC to undertake a new strategic plan for HIV prevention.**

Proportion of AIDS Cases, by Race/Ethnicity and Year of Report, 1985-1999, United States

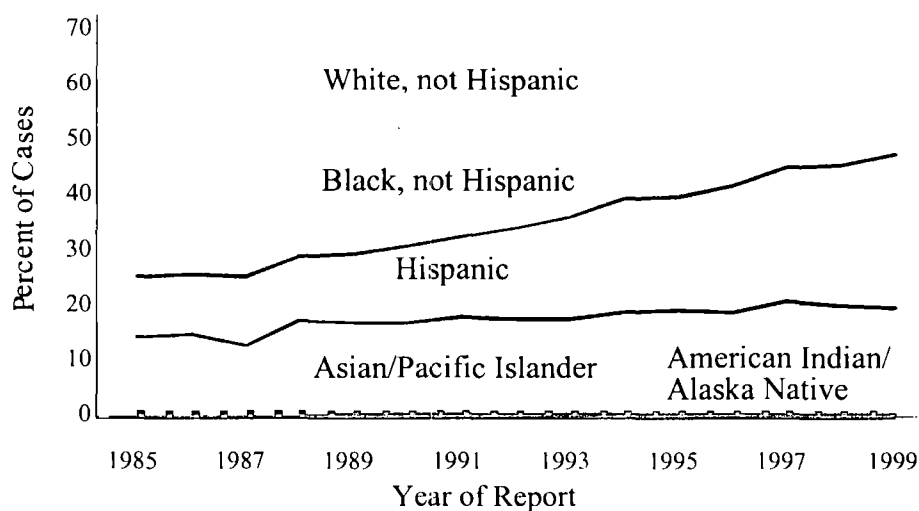


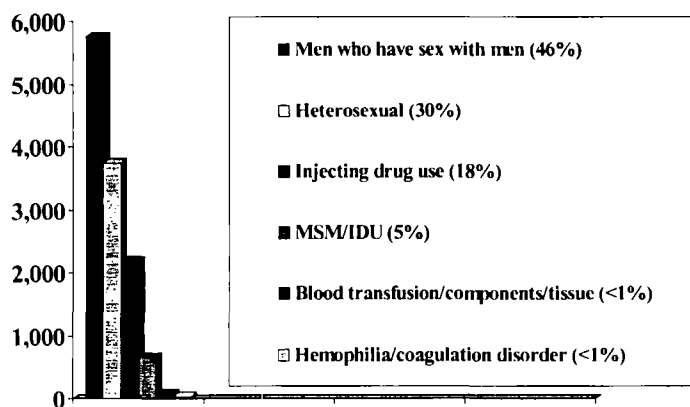
Fig. 1

CDC is the federal agency charged with preventing HIV infections and AIDS. But no one agency can do that alone. To accomplish that mission, and to meet other national goals for public health, such as those in *Healthy People 2010*, CDC works with partners such as other federal agencies including HRSA, HCFA, NIH, SAMHSA and FDA, state and local health and education departments, community-based organizations and private-sector firms, to conduct activities within three broad areas essential to achieving public health goals: recognition, intervention and evaluation. CDC's recognition activities – surveillance and research – help to better define and understand the various local HIV/AIDS epidemics across the nation. Intervention activities – prevention program implementation and technical assistance – based on behavioral, laboratory and medical science, work to contain the spread of HIV and AIDS. Evaluation activities – both program evaluation and policy research and development – assess intervention effectiveness and refine prevention approaches.

To develop this five-year strategic plan, CDC involved more than 100 experts from inside and outside the government: experts in behavioral science, epidemiology, care and treatment and the other disciplines required to address the HIV epidemic, community-based HIV prevention providers, members of infected and affected groups. These experts examined a situation analysis of the current epidemic, as well as a response analysis of CDC's current activities. They then divided into four workgroups, one for each of the three domestic goals and one for the international goal, to develop objectives and strategies to address each of the four goals. The goals, objectives and strategies begin on page 28. Background information on the strategic plan development process is in Appendix A, beginning on page 56.

How Are People Becoming Infected?

Adult and Adolescent HIV Infections By Known Risk[^] Reported in 1999*



[^]Total reported N= 21,186. Graph excludes 8,726 whose risk was not identified at the time of report.

*From the 32 areas with confidential adult and adolescent HIV reporting.

Fig. 2

In 1999, CDC received reports of 21,186 adult and adolescent HIV infections from 32 areas with adult and adolescent name-based HIV reporting (Fig. 2). The states reporting HIV infections did not include some of the areas hardest hit, such as California and New York – clearly, the numbers reported would rise considerably if all states and territories conducted HIV reporting.

The majority of cases reported in which the person's risk was known – 46 % – were among men who have sex with men. Heterosexuals, mostly women, represented the next largest category at 30%. Injecting drug use (IDU) accounted for 18% of the

reported cases classified by a specific risk. A significant percentage of cases were reported without a risk noted at the time of the initial report of HIV infection. NIR or “no risk reported or identified” cases are people whose cases are currently under investigation by local health departments; people who have died, declined to be interviewed or were lost to follow up; and people whose cases were investigated and no exposure could be identified. As NIR cases are investigated, people are reclassified into the proper exposure category if risk is determined.

Ever-Changing Epidemic

The AIDS epidemic continues to evolve, making inroads in vulnerable populations.

People of color, especially women, and young people are increasingly at risk, joining the rolls of the two groups historically hardest hit: men who have sex with men and injecting drug users.

People of color are increasingly at risk, as shown in the pie charts below.

- In 1997, HIV prevalence was higher among African-Americans than among any other racial or ethnic group surveyed. As Figure 3 below shows, it is estimated that half the men becoming infected are African-American; and the majority (60%) are MSM.
- In 1999, more African-Americans were reported with AIDS than any other racial/ethnic group. Approximately two-thirds (63%) of all women reported with AIDS were African-American and 42% of all men. African-American children represented almost two-thirds of all reported pediatric AIDS cases. In addition to suffering disproportionately from AIDS, African American women are also disproportionately infected with HIV. As shown in Figure 3, it is estimated that African American women account for 64% of new HIV infections among women.
- In 1999, Hispanics represented 13% of the U.S. population, but accounted for 19% of the total number of new AIDS cases reported that year. Latinas represent 18% of estimated new HIV infections among women and Hispanic men, 20% of estimated new infections among men (Fig. 3).

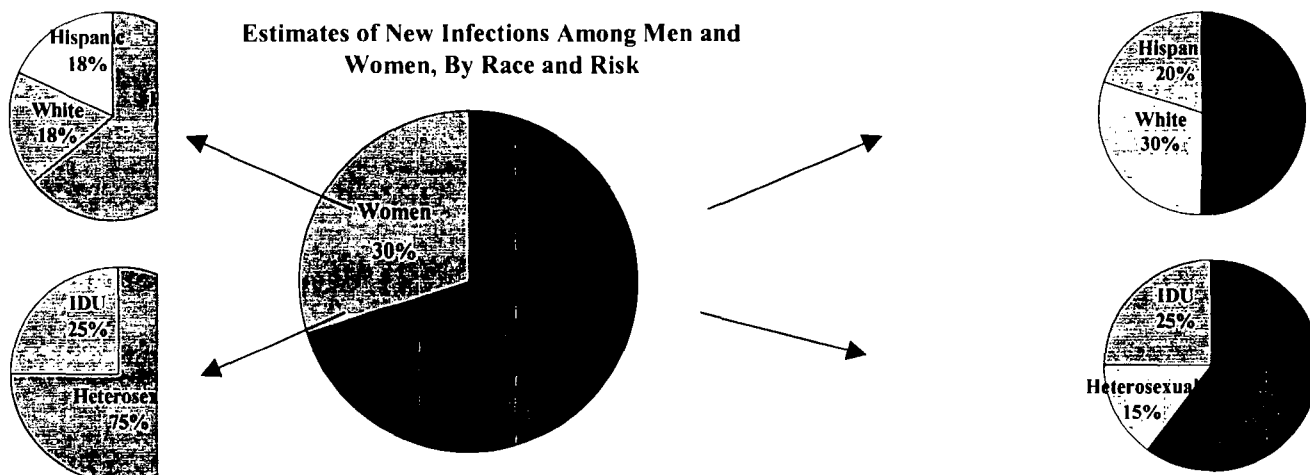


Fig. 3

Women. In 1992, women accounted for 13.8% of people living with AIDS. By end-year 1998, the proportion had grown to 20%. Figure 4 shows women's AIDS rates in 1998 by region and by race/ethnicity. AIDS case rates are highest in the Northeast, followed by the South. CDC estimates that between 120,000 and 160,000 adult and adolescent females are now living with HIV infection, including those with AIDS.

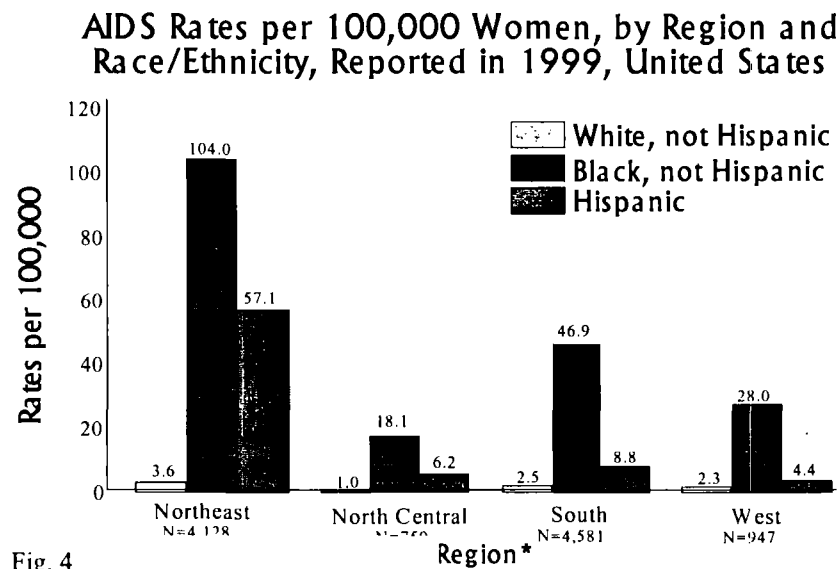


Fig. 4

Young people. It is estimated that about half of all new HIV infections are among young people under age 25, and the majority are infected sexually. In 1999, 1,813 young people ages 13 to 24 were reported with AIDS. Although the overall number of new AIDS diagnoses is declining, due to prevention and to highly effective drug treatment, a CDC analysis of HIV cases diagnosed in 25 states reporting HIV infections from 1994 to 1997 found no comparable decline in newly diagnosed HIV infections among youth. Figures 5 and 6 show AIDS cases reported through December 1999 by gender and age group.

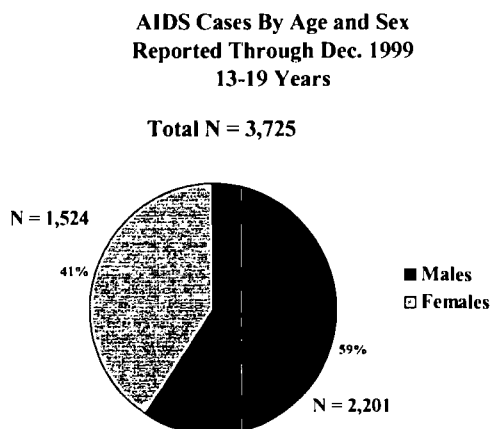


Fig. 5

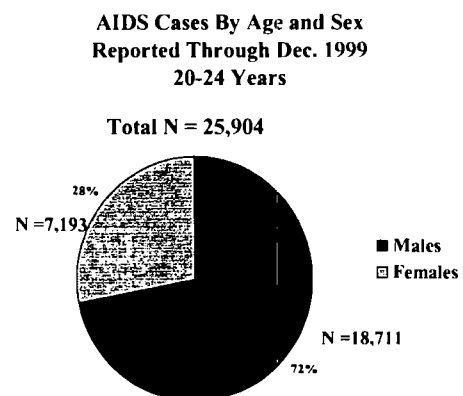


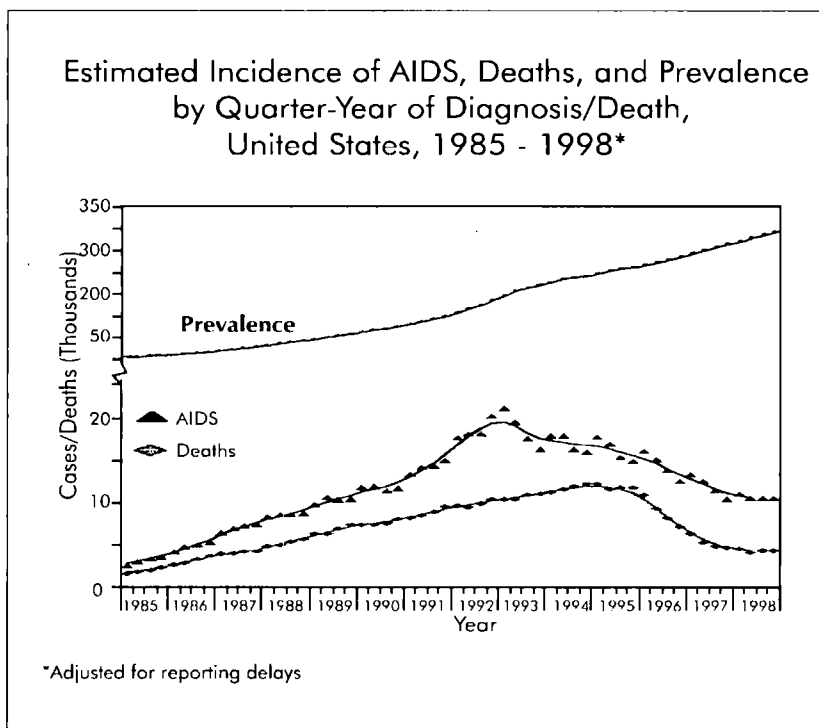
Fig. 6

Men Who Have Sex With Men. Gay and bisexual men of all races remain at alarming risk for HIV infection. In fact, risk may again be increasing in some communities, as evidenced by recent outbreaks of sexually transmitted diseases, particularly gonorrhea and syphilis, among MSM. Prevention issues include burn-out among older MSM, mistaken beliefs that HIV is no longer a serious disease, a new generation of young gay and bisexual men who must be reached and the unique cultural issues MSM of color face regarding both their race/ethnicity as well as their sexual orientation. A study of 1,942 HIV-infected gay and bisexual men in 12 U.S. cities found that a growing percentage reported engaging in unprotected anal sex. The proportion of gay and bisexual men who had unprotected anal sex during the previous 12 months rose from 13% in 1995-1996 to 19% in 1997-1998 – an increase of nearly 50%. HIV-infected MSM who had unprotected anal sex were more likely to have multiple partners, use injection drugs or crack cocaine and have less than 12 years of education.

IDUs (injecting drug users), their partners and their children account for 36% of all AIDS cases reported in the U.S. through 1999. They continue to be at risk for HIV infection, accounting for 16% of the cumulative HIV infections reported from areas with confidential HIV infection surveillance.

Successful Prevention Works At Multiple Levels

In an era of highly effective drug therapies, more people are living with HIV infection, as shown in the chart below (Fig. 7). CDC estimates that between 800,000 and 900,000 people



were living with HIV in the U.S. at the end of 1998. But optimism about treatment successes has led some people – both infected and uninfected – to become complacent about HIV prevention. Behavioral studies have shown that some people believe treatment advances make it less important to practice safer behaviors. As people live longer with infection, absent targeted behavioral interventions, they have the potential to spread infection. And, although HAART may reduce

Fig. 7

people's infectiousness, and thus their ability to transmit the virus to others, it is no substitute for primary prevention. HAART isn't suitable or effective for everyone. In the U.S. and around the world, people die everyday from AIDS, even those who had HAART.

People living with HIV need comprehensive care, including prevention case management services to prevent infecting others and to prevent complications of HIV infection. But estimates are that up to one-third of those living with HIV in America are unaware they are infected with HIV. The first step in securing needed prevention, care and treatment services is being tested for HIV and learning one's serostatus. Behavioral studies have demonstrated that, after learning they are infected, many people change their behavior, to avoid infecting others. Thus, learning one's status is, in itself, an important element of prevention. Continued prevention efforts are critical, emphasizing that there is no cure for HIV disease.

Successful prevention efforts avert HIV infection. The most successful prevention works at multiple levels simultaneously – at individual, social network and community levels, as well as at the structural level, addressing the sometimes hidden societal barriers to effective prevention.

The objectives and strategies that follow are designed to optimize the benefits of a continuum of HIV prevention and treatment, as reflected in the goals of the strategic plan. In this continuum:

Individuals determine their HIV status through voluntary counseling and testing as early as possible after their exposure to HIV.



If they test negative for HIV, they use the full array of existing prevention interventions and services to adopt and maintain HIV risk reduction [Goal 1].



If they test positive for HIV, they use quality prevention services and work to adopt and sustain lifelong protective behaviors to avoid transmitting the virus to others [Goals 2 and 3].



If they are HIV-infected, they enter the care system as soon as possible to reap the benefits of primary care and treatment [Goal 3].



Once in the care system, they benefit from comprehensive quality services, including mental health and substance abuse services, treatment for HIV infection, opportunistic infections and other infections, such as STDs and tuberculosis [Goal 3].



In conjunction with their providers and support networks, they work to develop strategies to optimize adherence to their prescribed therapies [Goal 3].

HIV Prevention Works

America's HIV prevention investments have paid off. Prevention has helped slow the rate of new HIV infections in the United States from over 150,000 in the mid 1980s to around 40,000 per year now – a remarkable decline, but new infections are still unacceptably high. AIDS remains a crisis in the U.S.

There are prevention tools that we know work. As detailed in CDC's *Compendium of HIV Prevention Interventions with Evidence of Effectiveness*, HIV prevention programs have been effective with a variety of populations: clinic patients, heterosexual men and women, youth at high risk, incarcerated populations, injection drug users and MSM. Interventions have been delivered to individuals, groups and communities, in settings ranging from storefronts to gay bars to health centers to public housing to schools.

For example, effective prevention among men who have sex with men, injection drug users and pregnant women helped ensure that –

- ◆ HIV seroprevalence among white MSM in the U.S. declined by 50% between 1988 and 1993.
- ◆ HIV seroprevalence among injection drug users in New York City dropped more than 40% during the 1990s.
- ◆ The estimated number of U.S. infants who acquired AIDS from mother-to-child transmission declined 75% from 1992 to 1998.

But prevention's successes have not been as evident among the populations now at greatest risk, particularly people of color, younger MSM and women. The challenge now is to develop targeted, sustained prevention that builds community capacity to deliver ongoing, lifelong prevention programming for those at risk and those already infected.

HIV Prevention Pays

HIV prevention pays. Researchers estimate that the cost of lifetime treatment for a person with HIV now averages about \$155,000. Estimates are that 40,000 people are infected yearly, resulting in an annualized cost of more than \$6 billion each and every year. The cumulative cost of lifetime treatment doubles yearly if the number of infections stays steady, as it has over the last decade. In the last 5 years alone, an estimated 200,000 people have been infected with HIV. Treating them over the rest of their lives will cost the nation \$31 billion, not counting inflation or further treatment advances that might add to costs.

At CDC's current budget level, only 4,000 infections must be prevented annually to actually result in cost savings, and only 1,300 must be prevented for the investment to be cost

effective. Most researchers agree that the number of infections actually prevented every year far exceeds the cost-savings level.

Further reductions in the number of people infected annually – and the concomitant reductions in human suffering – will be proportionate to funds invested. Our nation cannot reduce HIV infections further without additional investment. Level funding will likely not equate to a stable HIV epidemic. Instead, as more and more people live longer with disease and have

CDC's Domestic HIV Prevention Budget: \$637 M FY 99 Allocations

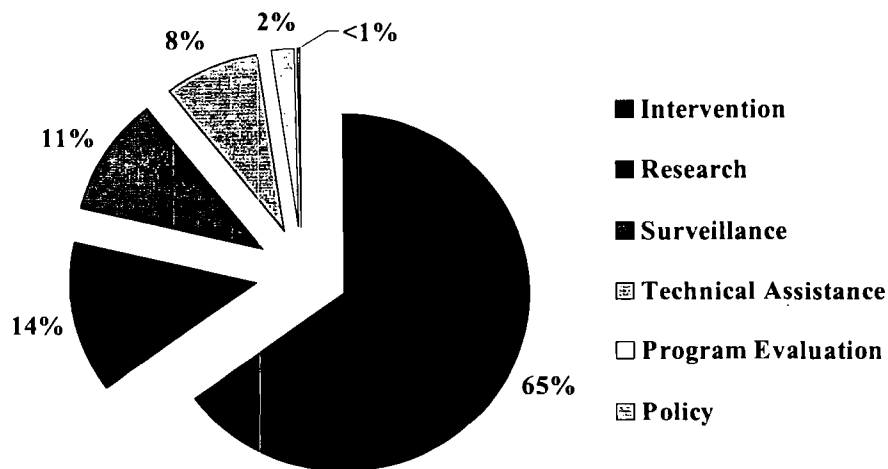


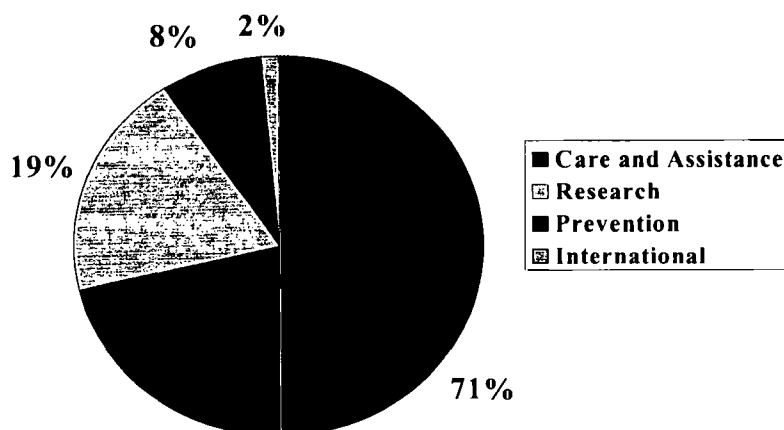
Fig. 8

the opportunity to infect others, level funding could actually translate into increases in HIV infection and AIDS.

CDC's fiscal year 1999 (or FY 99) domestic budget for HIV prevention was \$637 million, allocated along the proportions shown in the pie chart at left (Fig. 8).

To accomplish the four goals specified in this draft strategic plan, the nation will need to devote additional resources to HIV/AIDS prevention. Reducing new domestic infections by half will require substantial new resources over the agency's current base funding. The proportion of prevention dollars in federal HIV/AIDS spending, 8% of all monies allocated to HIV/AIDS in fiscal year 1999, is shown in Figure 9.

Federal HIV/AIDS Spending: FY 99



Source: Henry J. Kaiser Family Foundation. *Federal HIV/AIDS Spending: A Budget Sourcebook*, August, 1999.

Fig. 9

HIV Prevention Must Be Accountable

CDC's guiding principles in the strategic planning process are the same as they are for all our prevention programs:

- ▶ ***Effectiveness*** – CDC will evaluate its programs for effectiveness and require grantees to do the same, in order to ensure that our programs do the utmost to prevent HIV, given the resources provided to us.
- ▶ ***Accountability*** – CDC pledges to be accountable to the American people for conducting sound HIV/AIDS prevention activities.
- ▶ ***Transparency*** – CDC intends for its activities and funding to be clear to those outside the agency.
- ▶ ***Science-Based Activities*** – CDC's efforts will be based on the best science currently available.
- ▶ ***Collaboration and Partnerships*** – CDC will conduct HIV/AIDS prevention in conjunction with partners at all levels – federal, state and local – in the public sector, private sector and not-for-profit sector to address multiple local epidemics in the most efficient way possible.
- ▶ ***Comprehensiveness*** – CDC will continue its multifaceted approach to HIV prevention that includes strategies to address individual, community, societal and structural level prevention needs.

CDC's Goals for HIV Prevention

- 1. Reduce the number of new HIV infections per year in the United States from an estimated 40,000 to 20,000 per year by 2005.**
- 2. Through voluntary counseling and testing, increase the proportion of HIV-infected people in the United States who know they are infected from the current 70% to 95% by 2005.**
- 3. Increase the proportion of HIV-infected people in the United States who are linked to appropriate care, prevention services and treatment services from the current estimated 50% to 80% by 2005.**
- 4. Reduce HIV transmission and improve HIV/AIDS care and support through partnership with resource-constrained countries.**

Overarching Issues

As the four expert workgroups drafted and refined their recommendations to CDC, it became apparent that a number of issues crosscut all the goals, affecting HIV prevention at all levels. These issues are, in many instances, beyond the traditional purview of public health. For HIV/AIDS prevention to succeed, they must be addressed by a broad coalition of prevention partners, including public health, other social services agencies, faith communities, economic development agencies, health care purchasers, the justice system, the private sector and the so-called third sector, or not-for-profits and foundations, many of which are active and capable players in the HIV/AIDS arena.

Many of the issues that follow will be addressed in the action steps that will spell out implementation of this strategic plan. CDC will be developing the action steps following the public comment period on the plan. Among the most pressing cross-cutting issues are these:

Stigma associated with HIV/AIDS continues to profoundly affect prevention efforts, leading people to deny risk ... avoid testing ... delay treatment ... and suffer needlessly. While stigma's pernicious effects are perhaps most obvious in countries other than the U.S., where people may be shunned and physically menaced, stigma negatively affects Americans as well. It is found at the structural level, in the form of laws and regulations, as well as more explicitly at community and individual levels. Homophobia continues to hamper prevention efforts at all levels – from the individual at risk or infected, who may deny his risk because of internal conflicts – to the broader culture, which delivers anti-gay messages, institutionalizes homophobia through structural mechanisms such as laws that regulate intimate sexual behavior and lags in its support of sensitive and honest prevention for gay and bisexual youth, young adults and older men. Stigma associated with addiction and illicit drug use also results in laws and other restrictions on effective prevention. Likewise, persistent social and institutional racism and gender and economic inequities stifle effective HIV prevention. Planning workgroups agreed with CDC that, for each of these groups at risk, stigma, stereotyping and prejudice must be addressed for prevention to be most effective. Political leadership and will are necessary to address these underlying issues, so critical to prevention's success.

At home and abroad, HIV continues to stalk our most **vulnerable populations**, people who are marginalized because of race or ethnicity, sexual orientation, age or gender. For HIV/AIDS prevention to succeed, the **special needs** of those populations must be sensitively addressed, by **culturally competent** programs and staff. Cultural competence must be demonstrated not only by intervention programs and staff, but also by surveillance staff, researchers (and their investigations), as well as by those delivering prevention services, care and treatment programs to those who are HIV-infected.

In addition to cultural competence, CDC must assure that the programs it funds are of **documented prevention effectiveness**. Before holding grantees to this standard, however, the agency must work to ensure that training and technical assistance are available to help grantees succeed in delivering interventions of the highest possible quality. A key component of any quality improvement program will be evaluation – which requires not only training and technical assistance, but also adequate funding – to assess the effectiveness of prevention programming in order to make adjustments as necessary to ensure high quality.

Finally, to succeed, this plan requires a number of structural supports, including:

- *Better collaboration* between and among the various federal agencies with responsibilities for HIV/AIDS, substance abuse and STD prevention, research, care and treatment, including NIH, HCFA, HRSA, SAMHSA and FDA, as well as among federal, state and local partners. The plan demands continuity of care for persons

who are HIV-infected, moving seamlessly from testing and counseling to referral to care and treatment for HIV disease as well as other individual needs, such as STD treatment, drug treatment and ongoing prevention services. Absent strong linkages between and among programs, this plan cannot succeed.

- *Capacity-building* at all levels. No one knows more about a community than that community itself. CDC has always believed that, with the right kind of scientific support and technical assistance, communities are best able to identify their epidemics and how to fight them. Workgroups noted that surveillance information must be refined to give a better local picture and, beyond that, community planning groups, grantees and others will need a more extensive program designed to build local capacity to best address HIV/AIDS prevention needs.
- *Better measurement.* The workgroups noted that measurement activities will have to be increased to provide baseline data and ongoing evaluation of progress in meeting goals, objectives, strategies and action steps. In many instances, workgroups were frustrated that data were not available so that explicitly measurable objectives and strategies could be created.
- *Additional funding,* to address currently unmet gaps and needs. As noted earlier, at CDC's current funding, the goals of this plan cannot be accomplished.

How Will The Plan Be Used?

Following the comment period on this draft plan, which runs from September 11, 2000, to October 23, 2000, CDC anticipates finalizing the strategic plan during the remainder of calendar year 2000.

Concomitant with the public comment period on goals, objectives and strategies, action steps will be developed to direct agency efforts in accomplishing high priority strategies and objectives. The agency will also address the issue of relative prioritization. That is, CDC must determine whether each of the four goals is of equal priority. Additionally, the agency must address the question of prioritization within goals and determine how funding is best allocated among the priorities as the workgroups have defined them.

Upon completion, the plan will be used to:

- ***assess current budget allocations against the priorities in the plan and to realign spending as needed;***
- ***define unmet needs;***
- ***allocate new resources, if they become available;***
- ***direct prevention research;***
- ***highlight opportunities to strengthen collaboration across federal agencies and with other partners to enhance prevention;***
- ***assess the annual performance of CDC and its grantees in meeting priority goals, objectives and strategies;***
- ***serve as the basis of a yearly "report card" to the public on the activities of CDC and its grantees.***

Elements of Successful HIV Prevention

To succeed, HIV prevention must be comprehensive. These elements are required for HIV prevention to work:

- A community planning process
- Epidemiologic and behavioral surveillance; compilation of other health and demographic data relevant to HIV risks, incidence or prevalence
- HIV counseling, testing and referral and partner counseling and referral, with strong linkages to medical care, treatment and needed prevention services
- Health education and risk reduction (HE/RD) activities, including individual-, group- and community-level interventions
- Accessible diagnosis and treatment of other STDs
- Public information and education programs
- Comprehensive school health programs
- Training and quality assurance
- HIV prevention capacity-building activities
- An HIV prevention technical assistance assessment and plan
- Evaluation of major program activities, interventions and services

The following goals, objectives and strategies address each of these essential components of a comprehensive HIV prevention program.

Goal 1

Reduce the number of new HIV infections per year in the United States from an estimated 40,000 to 20,000 per year by the year 2005.

Objectives: Rank-Ordered Priority – Objectives are ranked from high (1) to lower (12) priority. Even lower priority objectives are considered important elements of comprehensive HIV prevention, and will not be eliminated from the array of CDC-sponsored activities. However, lower priority objectives may not receive supplementary or new resources.

1. Among people living with HIV, increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission or acquisition.
2. Among men who have sex with men (MSM), increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission or acquisition.
3. Among adolescents, increase the proportion who abstain from sexual intercourse or who use condoms consistently and correctly if sexually active.
4. Among injection drug users (IDUs), increase the proportion who abstain from drug use or who use harm reduction strategies to reduce risk of HIV transmission or acquisition.
5. Among at-risk sexually active women (including women who have sex with women), and at risk heterosexual men, increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission or acquisition.
6. Increase the proportion of people living with HIV and at highest risk for HIV who are tested for STDs and treated appropriately.
7. Increase the number of interventions of documented effectiveness and the proportion of providers funded by CDC that successfully provide demonstrably effective HIV prevention interventions.
8. Support realistic and feasible evaluation efforts to ensure the delivery of interventions of the highest possible quality.
9. Develop a monitoring system to estimate the number of new infections occurring each year in the U.S. and to provide locally relevant data for community planning.
10. Reduce perinatal transmission.
11. Reduce occupational HIV transmission.
12. Maintain safety of the blood supply.

Rationale

Decreasing new infections by half is an ambitious goal – but it can be accomplished with sufficient resources to deploy interventions of proven effectiveness.

To achieve this goal, resources must be directed to those most at risk, as demonstrated by sound epidemiologic and surveillance information. Men who have sex with men, injecting drug users and communities of color, particularly young women, must receive targeted, sustained, culturally appropriate prevention programming to break the cycle of HIV infection in America. Prevention must address the barriers to protective behaviors – barriers that are located within the individual, in the community and within the broader social context. For example, women may feel powerless to insist on condom use with partners, even though they know their partners are not monogamous. Communities may not insist on comprehensive HIV prevention programs in schools, even in the face of teen pregnancies and STDs, sure indicators that young people are also at risk for HIV infection. Our broader society may continue to condone discriminatory legislation, such as laws that criminalize certain sexual behaviors and make prevention a harder sell.

In order to cut new infections in half, all the factors that affect an individual's ability to make healthy choices must be addressed. Communities must be better equipped with local data to know who's at risk; they must have an array of effective interventions available and the capacity to implement and evaluate them at the local level; and they must be able not only to deter risky behavior but promote healthy behavior, through a variety of individual and group interventions, community-level supports and structural level changes.

The goal of cutting new infections in half will not be achieved without accomplishing the other two domestic goals. Ensuring that all those infected with HIV are aware of their status, in order to receive the benefits of improved HIV therapies as well as the benefits of counseling and support they need to reduce the risk of infecting others, is vital, as described in goal 2 beginning on page 37. Additionally, HIV prevention must be integrated with other services, such as STD and TB screening and treatment, reproductive health services, mental health services and drug use prevention and treatment, as described in goal 3, beginning on page 42. Those at risk for or living with HIV infection are often also at risk for other health problems. Integrating services, making it easier for people to seek and receive care and prevention interventions, will increase effectiveness as well as efficiency.

Clearly, CDC must work with a broad array of partners – other federal agencies such as HRSA, HCFA, NIH and SAMHSA; state and local health and education departments; community-based organizations; faith groups; and the private sector, including health care providers, the media, large purchasers of health insurance and others – to achieve the goals of this strategic plan.

Objectives and Strategies – Objectives are ranked from high (1) to lower (12) priority. Even lower priority objectives are considered important elements of comprehensive HIV prevention, and will not be eliminated from the array of CDC-sponsored activities. However, lower priority objectives may not receive supplementary or new resources. Strategies are rank-ordered in terms of their priority.

Objective 1: Among people living with HIV, increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission or acquisition.

Strategies:

1. Develop and implement community and structural interventions to reduce stigma and discrimination surrounding HIV infection.
2. Develop, implement and evaluate voluntary, peer-based HIV prevention interventions (individual, couples, groups, community, social marketing and structural level interventions) that address the diversity of individuals and populations living with HIV and their partners.
3. Conduct research to determine the most effective ways to involve HIV-infected persons as peer educators and counselors, and to involve them in the design and development of prevention strategies.
4. Support partner counseling and referral services to assure that partners potentially exposed to HIV receive testing and counseling and appropriate early evaluation and care.

Objective 2: Among men who have sex with men (MSM), increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission or acquisition.

Strategies:

1. Develop, implement and evaluate evidence-based HIV prevention programs for gay men, particularly MSM of color and young MSM, as indicated by local epidemiologic data.
2. Work with non-governmental organizations, the private sector and others to address the negative effects on prevention of stigma and discrimination associated with sexual orientation.
3. Based on local epidemiologic data, develop, implement and evaluate evidence-based HIV prevention programs for persons at increased risk for HIV who use alcohol and other drugs.

Objective 3: Among adolescents, increase the proportion who abstain from sexual intercourse or use condoms consistently and correctly if sexually active.

Strategies:

1. Develop, implement and evaluate evidence-based, community-based HIV prevention programs that help adolescents delay intercourse and help them develop safer sexual practices, particularly for adolescents in high-risk situations, especially out-of-school youth, gay/lesbian/ bisexual/transgender and questioning youth, youth in detention, run-away youth and youth of color.
2. Develop, implement and evaluate evidence-based comprehensive school-based HIV prevention programs that help adolescents delay intercourse and help them develop safer sexual practices, particularly for youth of color.
3. Coordinate/collaborate with SAMHSA, NIH and other partners to increase the research on effective programs that help adolescents prevent abuse of alcohol and other drugs and increase the awareness of the connection between drug use and sexual risk-taking.
4. Develop, implement and evaluate evidence-based programs for positive family communication around sexual behavior.

Objective 4: Among injecting drug users (IDUs), increase the proportion who abstain from drug use or who use harm reduction strategies to reduce risk of HIV transmission or acquisition.

Strategies:

1. Collaborate with SAMHSA, NIH and other partners to develop, disseminate, implement and evaluate health education/risk reduction (HE/RR) and harm reduction programs and voluntary HIV counseling and testing (VCT) programs targeting IDUs.
2. Work with other federal, state and local partners to increase comprehensive services for IDUs, including HIV/STD testing, drug treatment, methadone maintenance and harm reduction programs to promote non-sharing of injection equipment and use of sterile injection equipment.
3. Work with federal partners, corrections institutions, health departments and CBOs to provide incarcerated individuals with HE/RR and linkages to HIV and substance abuse prevention programs, mental health programs and other community-based services.
4. Continue to disseminate the scientific evidence that needle exchange programs are effective in reducing HIV infection while not increasing drug use.
5. In localities where needle exchange programs exist, encourage CDC grantees (who may interact with the same population using the exchange) to provide comprehensive HIV/STD education, VCT and referral to drug and mental health centers.
6. Collaborate with other federal agencies to develop, implement and evaluate prevention strategies that address non-injection drug use (e.g., crack cocaine, crystal methamphetamine) as a co-factor for HIV transmission.

Objective 5: Among at-risk sexually active women (including women who have sex with other women), and at-risk heterosexual men, increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission or acquisition.

Strategies:

1. Develop, implement and evaluate evidence-based HIV prevention programs that strengthen the capacity of women, especially women of color, to make decisions to reduce their sexual risk and increase their protective behaviors (e.g., correct, consistent and appropriate condom use, reductions in higher risk sexual practices with multiple partners).
2. Collaborate with NIH, FDA, private industry and other partners to increase the availability and acceptability of female-controlled HIV/STD prevention technology (e.g., microbicides and female condom).
3. Increase the research on the effectiveness of providing HIV prevention interventions in STD clinics, primary care and family planning settings, especially in communities of color.
4. Increase consistent and correct condom use by men, especially in communities of color.
5. Based on local epidemiologic data, develop, implement and evaluate evidence-based HIV prevention programs for persons at increased risk for HIV who use alcohol and other drugs.

Objective 6: Increase the proportion of people living with HIV and at highest risk for HIV who are tested for STDs and treated appropriately.

Strategies:

1. Increase awareness of HIV prevention providers of how STDs impact health and increase risk of HIV transmission and how to appropriately test and care for patients with STDs.
2. Increase the percentage of primary care providers for people at risk for HIV and living with HIV who perform routine and periodic testing for STDs.
3. Increase awareness among people living with HIV and people at increased risk for HIV of how STDs impact health and increase risk of HIV transmission.
4. Increase access to STD clinical care for people at increased risk for HIV and STDs by expanding service delivery venues to community-based organizations and non-traditional venues.
5. Increase the number of public HIV counseling and testing sites offering voluntary STD screening.

Objective 7: Increase the number of interventions of documented effectiveness and the proportion of prevention providers funded by CDC that successfully provide demonstrably effective HIV prevention interventions.

Strategies:

1. Promote a collaborative partnership model of intervention research, development and dissemination among prevention providers, affected populations, federal partners (e.g., NIH and SAMHSA), health departments, community planning groups, education departments and researchers to develop and test best interventions.
2. Fund evaluations of field-based intervention programs with strong reputations to identify additional effective interventions.
3. Conduct field efficacy trials of research-proven interventions implemented by non-researcher prevention programs.
4. Identify and address gaps and deficiencies in HIV prevention science, especially for target populations with fewer interventions of documented effectiveness, such as MSM of color and transgender persons.
5. Develop and support multiple mechanisms for identifying, evaluating and communicating best practices from the field (i.e., non-research, service provision settings) to community planning groups, directly funded CBOs and other prevention partners.
6. Fund intervention research projects with CBOs and health departments and require them to have a plan to sustain the interventions after the research projects end, whenever researched interventions are shown to be effective.
7. Institute evaluation and feedback to CDC on its technology transfer/diffusion, technical assistance and capacity-building initiatives.
8. Establish a mechanism(s) for ongoing dialogue and communication between CDC, CBOs, federal partners, health departments, community planning groups and researchers about technology transfer/diffusion.

Objective 8: Support realistic and feasible evaluation efforts to ensure the delivery of interventions of the highest possible quality.

Strategies:

1. Work with other federal partners funding HIV prevention (for example, SAMHSA) to standardize process and outcome evaluation protocols and institute minimum standard process evaluation measures consistent with evaluation requirements of other federal partners funding HIV prevention.
2. Fund rigorous process, outcome and impact evaluation for HIV prevention programs and provide technical assistance to facilitate adoption.

Objective 9: Develop a monitoring system to estimate the number of new infections occurring each year in the U.S. and to provide locally relevant data for community planning.

Strategies:

1. Explore the feasibility, and if feasible, develop a sampling frame to assess prevalent and incident HIV cases in sentinel sites or communities across the country; use modeling techniques to project an estimate of the new HIV infections occurring each year in the U.S.
2. Use new technology to assess incident cases as part of the monitoring effort and as part of state-based HIV case surveillance.
3. Develop, implement and evaluate measures of the prevalence of behavioral risk to help quantify the behavioral objectives presented in this plan.
4. Develop guidelines and provide support for systems to assist state and local health departments and education departments to better assess risk factors and the social context of new HIV infections and to communicate these findings in useful ways to planning groups and CBOs.
5. Provide technical assistance and resources to state and local health departments that wish to establish monitoring strategies similar to the national monitoring system.

Objective 10: Reduce perinatal transmission.

Strategies:

1. Work with other federal partners and private health care providers to routinize voluntary HIV counseling and testing, with informed consent, for all pregnant women, including those with no prenatal care.
2. Work with the array of professional organizations (e.g., physicians, midwives and nurses associations), medical, midwifery and nursing schools, the private medical sector (e.g., managed care organizations) and other federal partners to increase HIV-infected women's and HIV-exposed infants' early access to appropriate prevention (including elective cesarean section) and treatment.
3. Ensure that all jurisdictions have the necessary surveillance data on HIV in childbearing-aged women, pregnant women and perinatally exposed children to plan, target and evaluate programs to reduce perinatal transmission.
4. Work with federal partners, state and local health departments and providers to increase utilization of early and comprehensive prenatal care for all pregnant women, regardless of income, insurance or ability to pay.
5. Work with other partners to research the barriers to the use of AZT for perinatal HIV prevention by women at high risk.
6. Work with other partners to assess the effects of rapid screening on testing rates among women with no prenatal care in labor.
7. Work with other partners to assess the effectiveness of ultra-short antiretroviral regimens for pregnant women who do not obtain care until labor and delivery.

Objective 11: Reduce occupational transmission of HIV.**Strategies:**

1. Encourage the availability and use of effective engineering controls (e.g., engineered sharps injury prevention devices) and personal protective equipment (e.g., gloves) and their use by health care workers.
2. Advocate for interventions in health care facilities (e.g., engineering controls, personal protective equipment, work practices, work organization and health communication strategies) that are effective in reducing exposure to blood and body fluids among health care workers.
3. Implement surveillance systems to track the distribution and determinants of bloodborne exposures (including the surveillance of effective interventions) and their trends over time among health care and other exposed workers in all settings.
4. Encourage the use of work practices that reduce exposures to blood and body fluids by health care workers and the modification of work organization factors (e.g. staffing and management commitment to safety) that impact exposures to blood in health care facilities.
5. Encourage the use of health communication strategies that convey effective techniques for reducing exposure to blood and body fluids among health care workers.
6. Work with employers and insurers to provide information about post-exposure prophylaxis and the importance of seeking appropriate and timely post- exposure treatment to health care workers (including emergency response workers).

Objective 12: Maintain safety of the blood supply.**Strategy:**

1. Continue to monitor and preserve the safety of the blood supply.

GOAL 2

Through voluntary counseling and testing, increase the proportion of HIV-infected people in the United States who know they are infected from the current 70% to 95% by 2005.

Objectives: Rank-Ordered Priority – Objectives are ranked from high (1) to lower (4) priority. Even lower priority objectives are considered important elements of comprehensive HIV prevention, and will not be eliminated from the array of CDC-sponsored activities. However, lower priority objectives may not receive supplementary or new resources.

1. Increase the motivation of individuals to know their infection status and decrease real and perceived barriers to HIV testing.
2. Improve access to voluntary HIV counseling and testing (VCT) in high seroprevalence communities and populations at risk.
3. Increase the number of providers who routinely offer VCT for HIV in health care settings, including antenatal settings, as well as other venues.
4. Increase the percentage of people who know their results after HIV testing.

Rationale

In order for HIV-infected people to receive the benefits of improved HIV therapies and prophylaxis for opportunistic infections, as well as of the benefits of counseling to reduce the risk of infecting others, these individuals need to know their infection status. While all at-risk sexually active people should be encouraged to be counseled and tested for HIV, prevention resources for counseling and testing must be targeted to those whose behaviors place them at increased risk for infection. Strategies for those who deny their risk, those who recognize their risk but have not been tested and those who underestimate or are unaware of their risk will all be different. Targeted approaches for each group are essential. Special emphasis should be placed on youth at high risk to learn their status early – and when HIV negative, to maintain that status through prevention.

To achieve the goal of increasing the proportion of HIV-infected Americans who learn their serostatus through high-quality, client-centered voluntary counseling and testing,* several crosscutting strategies must be implemented or maintained:

- To maximize the acceptance and delivery of testing services in at-risk communities, HIV counseling and testing must be done in ways that address the cultural variations of our nation's diverse communities.
- CDC programs designed to increase knowledge of HIV infection status must be developed in collaboration with national, state and local partners (both government and non-governmental organizations) and with input from community leaders.
- New rapid testing technologies should be evaluated to enable testing in nontraditional settings, such as street outreach programs, and to provide screening test results during initial patient encounters.
- Partner notification services to identify at-risk people who should be offered testing should be increased.
- All public health jurisdictions should ensure the availability of anonymous HIV testing.

* Note: As described in CDC's guidelines for counseling and testing (including laboratory guidelines).

Objectives and Strategies – Objectives are ranked from high (1) to lower (4) priority. Even lower priority objectives are considered important elements of comprehensive HIV prevention, and will not be eliminated from the array of CDC-sponsored activities. However, lower priority objectives may not receive supplementary or new resources. Strategies are rank-ordered in terms of their priority.

Objective 1: Increase the motivation of at-risk individuals to know their infection status and decrease real and perceived barriers to HIV testing.

Strategies:

1. Work with a broad array of partners to identify, develop, implement and evaluate strategies to address real and perceived barriers to testing – such as fears concerning stigmatization, criminalization, partner notification, violence, risk of deportation and confidentiality (including the impact of implementing HIV named reporting) – at an individual, community, societal and structural level.
2. Study the effects of risk-denial on individual motivation to be tested and implement strategies to overcome this barrier.
3. Develop and implement effective marketing strategies to promote testing in at-risk groups, including enhancing the at-risk public's knowledge of primary infection indicators.
4. Use mass media outlets and community-based communications networks to disseminate news information related to testing matters quickly (generally within 24 hours of an event).
5. Support the development and application of new models of voluntary HIV counseling and testing, including couples testing, group-based approaches and alternative methods of providing results.
6. Support the use of tests that do not require needles (e.g., tests of saliva and urine).
7. Increase patient-level interventions to encourage those at-risk for HIV infection to request testing, such as tear-off or check-off slips to request a test.

Objective 2: Improve access to voluntary counseling and testing (VCT) in high seroprevalence communities and populations at risk.

Strategies:

1. Increase access to anonymous and confidential testing.
2. Increase the proportion of persons with conditions (e.g., tuberculosis, sexually transmitted diseases and hepatitis C) and/or behaviors (such as unprotected sex and multiple partners, substance abuse) that indicate HIV risk who are offered VCT.
3. Evaluate the effectiveness of various types of partner notification programs in order to increase the proportion of at-risk sexual or needle-sharing partners who are notified of their risk; receive counseling and voluntary testing; return for their test results; and, if infected, are referred to follow-up or, if negative, receive prevention services to reduce their risk.

4. Increase the availability of free or low-cost testing at both clinical and non-clinical sites, such as community-based organizations, street outreach programs, faith-based service centers and family planning clinics in high seroprevalence areas.
5. Support public health agencies to assist state and local correctional facilities, including juvenile detention facilities, as well as probation and parole systems, to provide HIV educational services and VCT.
6. Increase the numbers of sexually active youth and young adults who are routinely offered VCT.
7. Increase the number of providers who routinely offer VCT to all pregnant women.

Objective 3: Increase the number of providers who routinely offer VCT for HIV in health care settings, including antenatal settings, as well as other venues.

Strategies:

1. Conduct studies to determine the effects of different pre-test counseling and consent approaches on provider willingness and ability to offer routine VCT.
2. In collaboration with professional organizations, develop guidance on the healthcare settings and patient populations for which VCT should be considered a standard of care.
3. Develop and implement education and training initiatives for physicians, nurses and other health care providers to promote and enhance quality of VCT.
4. Collaborate with HCFA, managed care associations and health plans to promote VCT for appropriate enrollees.
5. Work with health departments and community planning groups to increase funding appropriately for needed VCT services, and collaborate with other agencies (HCFA, HRSA, SAMHSA) to increase reimbursement to providers.
6. Work with other federal agencies (e.g., HRSA) and other health care providers (e.g., managed care) as well as professional organizations to increase provider recognition of primary HIV infection and awareness of other medical conditions that may also be indicative of HIV disease in order to promote appropriate testing.
7. Work with public and private health care entities to increase both provider-level and systems-level interventions to increase HIV testing. [Provider-level interventions include encouraging the use of electronic or other “passive” reminder systems (e.g., chart flags, reminder pop-ups on electronic medical record) to identify persons who would benefit from HIV testing or retesting. Systems-level interventions include increasing coverage of HIV testing as a health benefit.]
8. Collaborate with other agencies and partners (e.g., the private sector) to increase the availability of urine-based HIV testing that can be easily coupled with STD testing using the same specimen.

Objective 4: Increase the percentage of people who know their results after testing.**Strategies:**

1. Support the use of rapid tests to provide same-day screening results as well as other mechanisms to reduce turnaround time for results (e.g., saliva and urine tests).
2. Evaluate and monitor grantees' rates of client return to receive test results and work with grantees to increase rates of return if necessary.
3. Determine the effect of patient incentives and other strategies on increasing return rates.
4. Evaluate the impact of various forms of pre-test counseling on client satisfaction and return rates of sero-positives; provide guidance regarding optimal counseling content, delivery, messenger and context in order to increase return rates.
5. Increase follow-up for sero-positives who don't return for their results, including pregnant women in antenatal settings.

Goal 3

Increase the proportion of HIV-infected people in the United States who are linked to appropriate care, prevention services and treatment services from an estimated 50% to 80%.

Objectives – Rank-Ordered Priority – Objectives are ranked from high (1) to lower (11) priority. Even lower priority objectives are considered important elements of comprehensive HIV prevention, and will not be eliminated from the array of CDC-sponsored activities. However, lower priority objectives may not receive supplementary or new resources.

1. Work with public health, the private medical sector, HRSA and other partners to reduce the disparities in access to prevention and care services that are experienced by communities of color and by women.
2. Work with public health, the private medical sector and other partners (e.g., SAMHSA, HRSA) to increase the percentage of persons who have been diagnosed with HIV who are successfully linked to culturally competent, science-based behavioral prevention services (safer sex, substance use, needle hygiene, partner services, STD symptoms and management, adherence to treatment) beyond post-test counseling.
3. Work with public health, the private medical sector, HRSA and other partners to increase the percentage of persons diagnosed with HIV who are successfully linked to care within 3 months of learning their HIV status or of being re-identified as being HIV-infected but out of care.
4. In collaboration with federal, state and local criminal justice systems, increase the percentage of correctional facility detainees (incarcerated for at least 30 days) identified as HIV-infected who are provided HIV prevention, treatment and care services and who, upon release, are successfully linked to those services in the community to which they return.
5. Work with public health, the private medical sector, HRSA and other partners to increase the proportion of HIV care providers offering routine, periodic STD screening and treatment to HIV-infected clients.
6. Work with public health, the private medical sector, HRSA and other partners to increase the proportion of HIV care providers offering routine, periodic TB screening and treatment to HIV-infected clients.

7. Work with public health, the private medical sector, HRSA and other partners to increase the proportion of HIV-infected persons who have a comprehensive, culturally competent, individualized assessment of their need for social, mental health, substance abuse treatment and behavioral prevention services, as well as medical care and treatment services, within 6 weeks of being identified as HIV-infected.
8. Work with public health, the private medical sector, HRSA and other partners to increase the proportion of persons diagnosed with HIV who need social and mental health services who are successfully linked to those services.
9. Work with public health, the private medical sector, HRSA, SAMHSA and other partners to increase the proportion of persons diagnosed with HIV who need substance abuse treatment services who are successfully linked to those services.
10. Through collaborative research, advocacy and facilitation, integrate optimal prevention services, including adherence to treatment, for persons with HIV and AIDS into the delivery of patient care in both public and private sectors.
11. Collaborate with other agencies and providers directly responsible for patient care to promote the optimal level of medical services for patients diagnosed with HIV to benefit individual health and reduce the likelihood of further transmission of HIV.

Rationale

All infected people – regardless of when in the course of their illness they become aware they have HIV – are included in the following objectives and strategies. Clearly, it is ideal for people to begin treatment as soon as possible after infection. But many people live far from the ideal, and may be infected for some time before seeking treatment and prevention services. The tactics to reach those who are newly infected and those who have been living with infection but have been out of care are different, and are described differently in the following objectives and strategies. While the tactics are different, what is similar is the universal requirement that CDC coordinate and collaborate with other public health agencies, such as the Health Resources Services Administration, Health Care Financing Administration and the Substance Abuse and Mental Health Services Administration, as well as other federal partners, and with the private medical sector, to achieve the objectives and strategies for this goal.

The goal also seeks to address two complementary but distinct types of services for people infected with HIV – services directed toward supporting their efforts to prevent further transmission and services directed toward their care and treatment. Setting separate objectives for each set of services highlights the difference in CDC's role. Prevention services must be made an integral part of care, and linking people into care and treatment goes beyond medical care to the comprehensive care necessary for an infected individual that will support prevention efforts.

CDC does not have responsibility for care for infected individuals. CDC is responsible, however, for HIV prevention and for preventing HIV-associated morbidity and mortality. Thus, many of the objectives and strategies that follow call for CDC to coordinate with other agencies whose chief responsibilities are care, in order to institute the ongoing counseling and prevention messages that are needed throughout care. Recent outbreaks of syphilis and gonorrhea among HIV-infected MSM and evidence that some HIV-infected patients on multi-drug therapy are reverting to unsafe sex practices attest to the importance of ongoing prevention for HIV-infected individuals and suggest that prevention is likely to be an efficient use of resources to prevent HIV transmission as well as to keep HIV-infected people healthy.

Effective prevention efforts must address the spectrum of needs of those who are infected. An individual's HIV status, while important from a public health perspective, may not be a top priority for the infected person. Care for HIV-infected people must be comprehensive, and reflect the fact that counseling for mental health, substance abuse and social service needs and linkage to required services helps the prevention effort and is also the right thing to do.

Objectives and Strategies – Objectives are ranked from high (1) to lower (11) priority. Even lower priority objectives are considered important elements of comprehensive HIV prevention, and will not be eliminated from the array of CDC-sponsored activities. However, lower priority objectives may not receive supplementary or new resources. Strategies are rank-ordered in terms of their priority.

Objective 1: Work with public health, the private medical sector, HRSA and other partners to reduce the disparities in access to prevention and care services that are experienced by communities of color and by women.

Strategies:

1. Collaborate with HRSA, NIH, the affected communities and other partners to develop and implement a comprehensive research agenda, involving the HIV-infected populations to be studied, that identifies and addresses health seeking, sociocultural, economic and service system barriers that impede linkages to prevention services, particularly for communities of color and women.
2. Promote cultural and linguistic competence in CDC-funded prevention programs.
3. Build the capacity of prevention providers serving HIV-infected persons of color to deliver culturally competent prevention services.
4. Develop and test innovative strategies to enhance referral and comprehensive treatment programs for drug-using pregnant women.
5. Collaborate with AHRQ, NIH and other partners to develop the capacity for persons of color and women to submit proposals to CDC, AHRQ and NIH that address research on
6. HIV-infected minorities and women.

Objective 2: Work with public health, the private medical sector and other partners (e.g., SAMHSA, HRSA) to increase the percentage of persons who have been diagnosed with HIV who are successfully linked to culturally competent, science-based behavioral prevention services (safer sex, substance use, needle hygiene, partner services, STD symptoms and management, adherence to HIV treatment) beyond post-test counseling.

Strategies:

1. Assure that HIV-infected persons tested in CDC-funded sites obtain a comprehensive prevention assessment and appropriate referral to prevention case management (PCM) within 3 months of learning their HIV status.
2. Collaborate with HRSA to encourage the establishment and maintenance of prevention service components in public HIV/AIDS outpatient clinics.
3. Through technical assistance and collaboration with other partners, increase the capacity of HIV care providers (physicians, physician assistants, nurses in public and private settings) to provide brief behavioral prevention counseling to HIV-infected persons and to refer them to community-based organizations for further counseling as needed.
4. Work with HRSA and others partners to develop approaches to monitoring HIV-infected patients' linkage to prevention services.

5. Collaborate with other federal agencies and private health care providers to integrate HIV prevention services into public and private health care facilities that serve persons with HIV/AIDS, including the incorporation of performance measures into managed care contracts.
6. Increase the capacity of religious organizations to provide HIV prevention and support services for people with HIV/AIDS.
7. Promote the benefits of and provide technical assistance to large employers and employee health benefit purchasing coalitions to include language on HIV prevention in their managed care contracts.
8. Encourage organizations that accredit and license hospitals, correctional facility medical units and other health care facilities to incorporate HIV prevention policies into their accreditation standards.

Objective 3: Work with public health, the private medical sector, HRSA and other partners to increase the percentage of persons diagnosed with HIV who are successfully linked to care within 3 months of learning their HIV status or re-identified as being HIV-infected but out of care.

Strategies:

1. Publish guidelines for best practices for enhancing successful linkage from post-test counseling to care and patient use of recommended medical services.
2. Collaborate with HRSA and NIH to conduct research to determine the extent to which newly diagnosed HIV-infected persons successfully receive initial medical evaluation and to identify methods of enhancing linkage to care.
3. Collaborate with HRSA and other partners to conduct research to determine why previously diagnosed but currently out of care persons did not initially access or remain in medical care, and develop interventions to enhance linkage to care.
4. Develop a system to measure and monitor the linkage of HIV-infected persons from CDC-funded counseling and testing sites into care.

Objective 4: In collaboration with federal, state and local criminal justice systems, increase the percentage of correctional facility detainees (incarcerated for at least 30 days) identified as HIV-infected who are provided HIV prevention, treatment and care services and who, upon release, are successfully linked to those services in the community to which they return.

Strategies:

1. Through collaboration with correctional facilities, public health and other agencies (e.g., HRSA), promote comprehensive HIV needs assessments for HIV-infected detainees and the provision of services indicated to prevent HIV and associated diseases such as TB, hepatitis C and other communicable diseases.
2. Through collaboration, promote programs to provide culturally competent pre-release discharge planning and linkage to community-based organizations for follow-up and case management services.

3. Provide resources and support for public health agencies and/or directly funded community organizations to assure that identified HIV-infected persons released from correctional facilities are successfully linked to ongoing prevention, care, mental health, substance abuse and community services within their communities.
4. Provide resources and/or support to public health and criminal justice agencies and CBOs to facilitate access to education, counseling and testing and early intervention services for identified HIV-infected individuals in alternative sanction programs (e.g., drug courts) and probation programs.
5. In collaboration with partners, increase support for HIV-related services for inmates by demonstrating to key public health, criminal justice and community policy makers the economic, individual and public health benefits of preventing, identifying and treating HIV, STD and TB among incarcerated populations.
6. Evaluate the extent of provision of HIV prevention services to incarcerated persons and linkage of inmates to prevention and care services upon release.

Objective 5: Work with public health, the private medical sector, HRSA and other partners to increase the proportion of HIV care providers offering routine, periodic STD screening and treatment to HIV-infected clients.

Strategies:

1. Collaborate with HRSA, SAMHSA, Infectious Disease Society of America, other partners, agencies and organizations to increase awareness of HIV prevention providers of how STDs impact health and increase the probability of HIV transmission and acquisition and how to appropriately test and care for patients with STDs.
2. Increase the percentage of primary care providers for people with HIV who perform initial as well as ongoing, periodic risk assessment and STD screening and ongoing treatment as part of routine clinical care for HIV-infected persons in public, private and correctional settings.
3. Increase the number of HIV counseling and testing sites offering voluntary STD screening.
4. Increase awareness among people living with HIV of how STDs impact health and increase the probability of HIV transmission and acquisition.
5. Increase access to STD clinical care for people at increased risk for HIV and STDs by expanding service delivery venues to community-based organizations and non-traditional venues.
6. Better define the incidence of curable STDs in HIV-infected persons; assess extent to which current STD screening and treatment guidelines are being followed, and develop and issue recommendations on the frequency of screening HIV-infected persons for those STDs.
7. Recommend that all clinics counsel or refer for prevention counseling and partner counseling and referral services all HIV-infected persons who are diagnosed with a new STD.

Objective 6: Work with public health, the private medical sector, HRSA and other partners to increase the proportion of HIV care providers offering routine, periodic TB screening and treatment to HIV-infected clients.

Strategies:

1. Collaborate with HRSA, SAMHSA, Infectious Disease Society of America, American Lung Association, other partners, agencies and organizations to increase awareness of HIV care providers of how TB impacts health of patients with HIV disease.
2. Increase the percentage of primary care providers for people with HIV who perform TB screening and ongoing treatment as part of routine clinical care for HIV-infected persons in public, private and correctional settings.
3. Increase awareness among people living with HIV of how TB impacts the health of people with HIV disease.

Objective 7: Work with public health, the private medical sector, HRSA and other partners to increase the proportion of HIV-infected persons who have a comprehensive, culturally competent, individualized assessment of their need for social, mental health, substance abuse treatment and behavioral prevention services, as well as medical care and treatment services, within 6 weeks of being identified as HIV-infected.

Strategies:

1. Conduct research and demonstration programs to develop, implement and evaluate models and best practices for conducting HIV prevention case management needs assessment, including the need for ongoing integrated services such as mental health or substance abuse treatment and social services.
2. In conjunction with public and private sector partners, develop, disseminate and evaluate guidelines for conducting HIV prevention case management needs assessment.
3. Build capacity of CDC-supported HIV prevention counselors to conduct prevention case management needs assessments.
4. In conjunction with public and private sector partners, develop, implement and evaluate training programs to promote effective implementation of prevention case management needs assessment guidelines.

Objective 8: Work with public health, the private medical sector, HRSA and other partners to increase the proportion of persons diagnosed with HIV who need social and mental health services who are successfully linked to those services.

Strategies:

1. Increase capacity of CDC-supported HIV prevention counselors to link clients to social and mental health services.
2. Facilitate peer-to-peer technical assistance between states and regions that need assistance in developing programs for clients who need social and mental health services as part of their HIV prevention portfolio.

3. Collaborate with SAMHSA and other partners to increase the number of community coalitions that work on mental health, HIV prevention, HIV care and substance abuse issues to develop systems for broadening and referring newly diagnosed HIV-infected persons into appropriate social or mental health services.
4. Collaborate with SAMHSA and other federal agencies to promote the availability of services to those within the purview of the justice system.
5. Collaborate with SAMHSA to increase the availability of prevention services within culturally competent mental health services appropriate for age, gender and education level for people with both HIV disease and mental health disorders.

Objective 9: Work with public health, the private medical sector, HRSA, SAMHSA and other partners to increase the proportion of persons diagnosed with HIV, including pregnant women, who need substance abuse treatment services who are successfully linked to those services.

Strategies:

1. Collaborate with HRSA, SAMHSA and other prevention partners to develop, implement and evaluate the effectiveness of different approaches for successfully linking HIV-infected persons to needed substance abuse treatment services.
2. Develop policies and support practices to assure that HIV Prevention Community Planning Groups (CPGs) effectively identify and collaborate with state and local substance abuse agencies and with activities and programs related to SAMHSA's block grant programs to provide comprehensive integrated services to persons who need them.
3. Work with SAMHSA and others to develop approaches to monitoring linkage to substance abuse treatment services.
4. Collaborate with SAMHSA, HRSA and other partners to develop approaches to encourage women living with HIV who are pregnant and using illicit drugs to seek substance abuse treatment and prenatal care services.
5. Promote the use of best practices to involve drug users in the planning and implementation of programs designed for hard-to-reach drug users through emphasis on the participation of peers in delivering services to drug users, their sex partners and children.
6. Work with SAMHSA and state substance abuse agencies to integrate HIV and substance abuse prevention and treatment services.
7. Assist SAMHSA to estimate better the size of the treatment gap for illicit drug users.

Objective 10: Through collaborative research, advocacy and facilitation, integrate prevention services for persons diagnosed with HIV and AIDS into the delivery of patient care in both public and private sectors.

Strategies:

1. Collaborate with HRSA, HCFA (Medicaid, Medicare and SCHIP), SAMHSA and the Department of Justice to develop and evaluate models for integrating ongoing prevention, care, treatment and other support services for HIV-infected persons.
2. Work with HRSA, community planning groups and state AIDS directors to incorporate appropriate care elements into prevention planning and prevention elements into Ryan White Planning Councils.
3. Collaborate with HRSA, HCFA and NIH to develop recommendations and a program for limited, targeted directly observed antiretroviral therapy (DOT) and DOT-friendly HAART plus OI prophylaxis regimens.
4. Develop epidemiologic tools that use HIV-related laboratory reporting for surveillance purposes, such as viral load, CD4+ and HIV resistance testing, to analyze patterns of HIV care delivery and HIV resistance to help target outreach to providers and patients.
5. Promote nationwide laboratory and provider-based HIV reporting.
6. Collaborate with HRSA to build prevention interventions into the professional training curricula and activities of HRSA's AIDS Education and Training Centers.
7. In collaboration with other federal agencies, academic and professional organizations, seek incorporation of HIV prevention and treatment modules into medical and health sciences professional education.

Objective 11: Collaborate with other agencies and providers directly responsible for patient care to promote the optimal level of medical services for patients diagnosed with HIV to benefit individual health and reduce the likelihood of further transmission of HIV.

Strategies:

1. In collaboration with HRSA, HCFA and NIH, examine treatment patterns and characteristics of persons receiving and providers offering differing levels of treatment; use this information to provide guidance to practitioners concerning best practices and to develop recommendations for implementing care among diverse populations in order to achieve maximum individual and public health benefits from science-based treatments.
2. Monitor and assess pre-treatment anti-retroviral drug resistance among persons linked to care.
3. Continue to assess the utility of highly active antiretroviral therapy (HAART) as a means of preventing transmission of HIV and provide recommendations as needed.

Goal 4

Reduce HIV transmission and improve HIV/AIDS care and support through partnership with resource-constrained countries.

Objectives: Rank-Ordered Priority – Objectives are ranked from high (1) to lower (7) priority. Even lower priority objectives are considered important elements of comprehensive HIV prevention, and will not be eliminated from the array of CDC-sponsored activities. However, lower priority objectives may not receive supplementary or new resources.

1. Decrease sexually transmitted HIV infections.
2. Develop the capacity of partners in host countries for HIV prevention and care efforts.
3. Expand and strengthen HIV/STD/TB surveillance programs.
4. Improve basic scientific knowledge of HIV and the safety and efficacy of new technologies.
5. Decrease HIV infections from mother to child.
6. Increase access to improved HIV care and support.
7. Decrease parenterally transmitted HIV infections.

Rationale

The global AIDS epidemic is the moral, medical and political challenge of our time. Everyone, everywhere in the world, is affected by this crisis. And, while the epidemic is indeed global, it is composed of multiple, country-specific epidemics, which vary widely in their scope, their severity and their management. Each country's environment – the epidemiologic situation, health system characteristics, donor resources and state capacity – is uniquely its own. Therefore, each country's priorities will be uniquely its own. Likewise, intervention and research outcomes must be specific to country-level realities, so evaluation of outcomes and impacts will also be country-specific. Therefore, the objectives and strategies that follow are written broadly, to accommodate the unique needs of the various countries CDC and other governmental agencies (e.g., USAID) and non-governmental organizations (the World Bank, World Health Organization, Family Health International) partner with.

CDC has a long history of working successfully around the globe to address pressing health concerns, including HIV. The objectives and strategies to guide CDC's involvement in addressing the global AIDS epidemic are defined by these basic philosophical commitments:

1. ***Host-country involvement:*** Each partner country must have local ownership of and leadership in collaborative projects; there must be serious CDC commitment to in-country capacity building; and partner countries must play an active role in the conceptualization, implementation and evaluation stages of research and prevention projects.
2. ***Destigmatization of HIV in society:*** The efficacy of the recommended research and prevention strategies will be severely limited unless implemented in the context of destigmatizing HIV in partner countries.
3. ***Designing research and programs with sensitivity to gender, culture and age:*** Women, youth and other critical groups must participate in defining their needs, priorities, program and in addressing barriers to their health and empowerment.
4. ***Consideration of human rights:*** It is essential that the principles outlined in the United Nations Declaration of Human Rights are observed for each of the suggested strategies. There must be an increased awareness of and response to the tremendous barriers that exist to accessing expensive technologies such as diagnostics, drugs and information.
5. ***Political will:*** It is critical that political leadership of partner countries and the United States and other donor countries acknowledge the importance of the HIV epidemic, and overtly expresses the will of government to play a leadership role in HIV research and prevention activities.

Objectives and Strategies – Objectives are ranked from high (1) to lower (7) priority. Even lower priority objectives are considered important elements of comprehensive HIV prevention, and will not be eliminated from the array of CDC-sponsored activities. However, lower priority objectives may not receive supplementary or new resources. Strategies are rank-ordered in their priority.

Objective 1: Decrease sexually transmitted HIV infections.

Strategies:

1. Develop and evaluate behavioral interventions to reduce the risk of acquiring or transmitting HIV and other STDs, particularly for sex workers and their clients, displaced populations, in- and out-of-school youth, those in the workplace and for other locally relevant populations.
2. Expand voluntary counseling and testing for HIV.
3. Investigate the most effective intervention methods to address the role of STDs in HIV transmission and acquisition in a range of epidemiologic settings and to improve STD treatment services.
4. Implement prevention marketing programs for the general population.
5. Expand interventions for the prevention of sexually acquired HIV infections in women and in men, including MSM.

Objective 2: Develop the capacity of partners in host countries for HIV prevention and care efforts.

Strategies:

1. Work with partner country governments and communities to strengthen their capacity in the planning, implementation, evaluation, and monitoring of HIV intervention programs.
2. Work with communities in partner countries to decrease the stigma of HIV infection.
3. Build partners' capacity to develop, review and implement scientific and operational research protocols according to internationally accepted bioethical precepts.
4. Build the capacity of partner countries to procure and distribute antiretroviral drugs and other HIV-related products.
5. Work with communities in partner countries to prepare for trials of candidate HIV vaccines and microbicides.

Objective 3: Expand and strengthen HIV/STD/TB surveillance programs.

Strategies:

1. Strengthen HIV sentinel serosurveillance programs to monitor epidemic trends.
2. Strengthen the collection and use of behavioral data.
3. Strengthen laboratory testing for HIV including the implementation of quality assurance programs.
4. Promote the use of surveillance data for public health decision-making.

5. Assess the quality of surveillance programs.
6. Strengthen STD, AIDS and TB surveillance.

Objective 4: Improve basic scientific knowledge of HIV and the safety and efficacy of new technologies.

Strategies:

1. Evaluate the safety and efficacy of HIV vaccine candidates and vaginal microbicides and apply this knowledge in the field.
2. Conduct and apply HIV virologic research, focusing on the epidemiology, ecology and evolutionary biology of HIV infection.
3. Conduct HIV vaccine and microbicide preparedness work, including the development of relevant cohorts.
4. Evaluate and apply new laboratory tests for HIV diagnostics.

Objective 5: Decrease HIV infections from mother to child.

Strategies:

1. Expand access to VCT services for antenatal women during the prenatal period and/or at the time of delivery.
2. Conduct research on improving biomedical and behavioral methods to interrupt mother-to-child transmission in the prenatal, perinatal and postnatal periods; apply results to the field.
3. Expand access to antiretroviral drugs for HIV-infected pregnant women and their newborns.
4. Provide appropriate breast-feeding alternatives to HIV-infected women.
5. Study postnatal prophylactic and early weaning strategies to decrease breastfeeding transmission among HIV-infected women who choose to breastfeed.
6. Strengthen family planning services to expand options for HIV-infected women.

Objective 6: Increase access to improved HIV care and support.

Strategies:

1. Strengthen VCT programs to make critical linkages to care and support programs.
2. Work with communities to decrease stigma among HIV-infected persons.
3. Expand and strengthen programs that prevent and treat tuberculosis and other opportunistic infections in HIV-infected persons.
4. Conduct and apply research on the clinical management of HIV, including the prevention and treatment of opportunistic infections and cancers, in hospital, home and community settings.
5. Conduct and apply research on the psychological and social needs of people living with HIV/AIDS and people affected by AIDS.

6. Promote availability and affordability of AIDS control technologies such as diagnostics, antiretroviral drugs and therapies.
7. Conduct and apply research on the safety and efficacy of antiretroviral therapy.

Objective 7: Decrease parenterally transmitted HIV infections.

Strategies:

1. Strengthen capacity of countries to provide sufficient safe blood for transfusion.
2. Conduct and apply research on behavioral change methodologies, including targeted harm reduction programs, to prevent IDU-related transmission.
3. Strengthen the capacity of health care workers to prevent parenteral HIV infection to themselves and to patients.

Appendix A

Background Information on the Strategic Planning Process

In November 1998, CDC initiated a detailed review of its HIV/AIDS prevention activities. The overall purpose of this review was to identify HIV prevention program gaps and shortfalls. The process was co-led by the National Center for HIV, STD, and TB Prevention (NCHSTP) and the Office of Program Planning and Evaluation (OPPE) within the CDC Director's Office. The process was internal until June 1999, when the internal review was augmented by the formation of an external work group, composed of members of NCHSTP's Advisory Committee for HIV and STD Prevention and other outside experts. One of the chief recommendations of this group was that CDC develop a national plan for HIV/AIDS prevention.

On February 2-3, 2000, the first meeting to develop a comprehensive national plan for HIV/AIDS prevention, spanning all centers and HIV planning activities of CDC, was convened in Atlanta. Participants consisted of external collaborative partners, expert academicians, clinicians and organizational representatives. The external consultants were aided by a diverse group of CDC staff from all CIOs (Centers, Institute and Offices) with HIV responsibilities and activities. A list of the planning workgroup members is in Appendix B, page 58.

External and internal participants broke into four workgroups and were charged with developing and prioritizing **objectives and strategies** to meet CDC's three domestic goals and one international goal.

The workgroups were not asked to develop specific **action steps** to implement proposed strategies. These will be developed by CDC. However, based on their wide-ranging expertise, several workgroups suggested action steps, which are currently under consideration by CDC.

Each workgroup was chaired by an external consultant and co-chaired by a senior CDC staff person. Between February and April the workgroups held five face-to-face meetings and had 16 telephone conference calls to develop and refine their goals and to develop objectives and strategies to achieve the goals. An electronic bulletin board was established to share drafts of individual workgroup efforts, CDC guidance and other information pertinent to HIV and to strategic planning.

In April CDC held meetings with each of the four workgroups to evaluate their draft work plans. Gaps, omissions, overlaps and ambiguities were identified and discussed. Groups were requested to revise their plans based on the CDC input. Groups were also requested to prioritize their objectives and strategies. The following criteria for prioritizing objectives and strategies were provided by CDC:

- Impact on HIV transmission and/or acquisition. That is, the activity's impact on reducing HIV infections.
- Impact on the current (and projected) state of the epidemic. That is, extent to which this activity addresses populations at risk for infection or already infected.
- Scientific currency of the activity. That is, the degree to which the activity reflects the most up-to-date behavioral, biomedical, communications or other science.

Groups were also provided three alternative methods for applying these criteria to prioritize objectives and strategies.

Following revisions, the workgroups met in Atlanta on May 2-3, 2000, to present their draft workplans to each other and to a broader CDC audience for feedback. Based on this feedback, final workgroup plans for the four CDC goals were developed. Each workgroup prioritized its objectives and strategies as described at the beginning of each section detailing objectives and strategies for each of the four goals.

Appendix B

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HIV/AIDS - - An Expanded International Role for CDC

Problem: The affect of HIV/AIDS in Africa and Asia is devastating. Africa, for example, is the global epicenter for HIV/AIDS with an overwhelming 22 million adults and 1 million children living with HIV by the end of 1998. Botswana, for instance, has one of the highest documented rates of HIV infection in the world. Extensive HIV transmission started in Asia only 10 years ago. By 1999, there were an estimated 7 million Asians living with HIV and AIDS. Thailand has experienced about 1 million HIV infections, however, its successful HIV prevention program has slowed transmission substantially and is a model for the rest of Asia. CDC has established field sites and provided technical assistance to the Ivory Coast, Botswana, Kenya, Uganda, and South Africa since the late 1980s. We are currently engaged in a major initiative which implements the findings from CDC's short course AZT therapy trials conducted in West Africa to prevent mother to child HIV transmission. Since 1991, CDC has worked closely with the Ministry of Public Health (MOPH) of Thailand on a wide range of training and HIV prevention related activities. In Vietnam, increased travel between the United States, including travel among the 1 million Vietnamese-Americans residing in the U.S., may affect domestic disease control. Vietnam is experiencing significant health problems with other infectious diseases such as tuberculosis, hepatitis B and C, and dengue fever. To date, Vietnam has not yet been substantially impacted by HIV/AIDS, therefore the possibility of preventing a much larger HIV/AIDS epidemic exists if proactive assistance is provided soon. In India, the first case of HIV was detected in 1986. Currently, the Government of India and USAIDS estimate that there are between 3 and 5 million individuals with HIV infection in India, perhaps the largest number of infections of any country in the world.

Activity: Proposed HIV activities include: the development of Centers of Excellence to strengthen existing CDC activities in Uganda, Kenya, Ivory Coast, South Africa, Botswana, Thailand, Vietnam, India and possible broader regional involvement; demonstration projects; and sustained technical assistance. These centers would focus on HIV, STD, and TB surveillance, epidemiology and intervention research training and would serve as training sites for public health scientists. Areas of particular focus include: 1) comprehensive on-site technical assistance programs focusing on prevention and control of HIV/AIDS, other sexually transmitted disease (STDs), tuberculosis and other priority infectious diseases; 2) prevention of mother-to-infant HIV transmission; 3) surveillance, with a focus on incidence; 4) evaluation and implementation of new prevention methods and tools (e.g., HIV rapid tests, vaginal microbicides, HIV vaccines); 5) prevention of HIV transmission - intervention-linked research including behavior change and focus on increasing condom use for sexually active youth; 6) broader management of TB, including TB prophylaxis for HIV-infected persons, and other opportunistic infections such as PCP, and STD diagnosis and treatment; 7) HIV counseling and testing; 8) prevention of HIV transmission among injecting drug users; and 9) blood safety.

Benefits: Transfer to African and Asian countries the lessons learned in order to reduce HIV, STD, and TB transmission. Activities will provide an exchange of lessons learned that are applicable for U.S. health programs. These centers enhance and complement the current efforts of other prevention partners i.e. USAID, UNAIDS, UNICEF, and other donor agencies; Ministries of Health; NGOs; and other prevention partners. For example, UNICEF and UNAIDS are committed to supporting short-course antiretroviral interventions in Africa. Specific initiative funding would enable CDC to take a much more active role in bridging the gap between research results and program implementation and evaluation.

Budget:	Activities in Africa:	approximately \$20 million
	Activities in Asia:	approximately \$15 million (Vietnam: \$2 million; India: \$3 million; Thailand regional center: \$10 million)

Total Resources Needs **\$35 million**

Gary Conrad
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Addressing the Global Epidemic: CDC's International Activities

The Centers for Disease Control and Prevention's (CDC) research program is dedicated to advancing biomedical and behavioral science that promotes HIV/AIDS prevention in the United States and worldwide. Research focuses on understanding the dynamics of HIV transmission and on developing and improving prevention technologies and strategies to control the spread of HIV/AIDS and minimize its consequences.

The World Health Organization and the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimate that, worldwide, as many as 42 million people have been infected with HIV since the pandemic's onset, and each day 16,000 more become infected. Recognizing the urgency of the epidemic, CDC is committed to HIV/AIDS research within, as well as outside of, U.S. borders. To understand AIDS on a global level, research must address issues and conditions unique to different countries and communities within countries. Many developing countries severely affected by the epidemic lack the research capacity, public health infrastructure, and financial and human resources to respond to the epidemic. CDC's international research underscores the importance of developing and implementing diverse interventions to address issues among varied populations and to do so quickly and cost-effectively.

Cooperative Efforts Yield Prevention Benefits

Through collaborative agreements with governments of Côte d'Ivoire (*Projet RETRO-CI*) and Thailand (*HIV/AIDS Collaboration*), CDC participates in studies designed to increase our understanding of the epidemiology of HIV-1 and HIV-2 infections and to facilitate prevention and care efforts in the host countries and the United States. Specific research areas include:

- **Addressing mother-to-child (perinatal) HIV transmission** in developing countries around the world, where 1,600 babies are born with HIV each day. Collaborative research by CDC and the Thai Ministry of Public Health found that a short course of AZT given late in pregnancy and during delivery reduced the rate of HIV transmission to infants of infected mothers by half and is safe for use in the developing world. The findings offer real hope to many developing nations that previously had no realistic options to prevent HIV-infected pregnant women from transmitting infection to their babies. CDC continues working with host countries and public health agencies worldwide to implement the short course AZT regimen as widely as possible. Researchers continue to study other factors of mother-to-child HIV transmission, such as the role of breast-feeding in HIV transmission in developing countries where breast-feeding is an important source of nutrition for newborns.
- **Developing effective interventions for high-risk populations** in Côte d'Ivoire and Thailand. Researchers have collaborated with host countries to implement and evaluate HIV prevention interventions among injection drug users, female sex workers and other populations at risk to

provide them with the knowledge and support needed to protect themselves from HIV infection. Many of these interventions have proven effective, particularly programs to increase condom use and treat sexually transmitted diseases among female sex workers.

- ***Identifying possible factors that may confer immunity to HIV.*** Collaborative researchers from CDC and the Thai and Ivorian Ministries of Public Health are working to determine how certain groups of female sex workers have remained uninfected despite numerous exposures to HIV. Initial research looked at possible genetic characteristics that might lead to immunity in certain individuals and is now focusing on the role the immune response to HIV may play in protection from infection. Researchers believe this research could have important implications for the future development of an HIV vaccine.
- ***Working to reduce the impact of HIV/AIDS in developing countries through practical treatment regimens.*** A joint study by CDC and the Côte d'Ivoire Ministry of Public Health found the first evidence that trimethoprim/sulfamethoxazole (TMP/SMX) (commonly referred to as cotrimoxazole, Bactrim or Septra) can significantly reduce the rate of death among HIV-infected tuberculosis patients in Africa. New data demonstrate a 48% reduction in mortality and a 44% reduction in hospitalizations among HIV-infected tuberculosis patients taking TMP/SMX. These dramatic findings offer a realistic option to help reduce the overwhelming death toll from HIV in the developing world.
- ***Conducting genetic analyses and collecting surveillance data on the genetic variations of HIV*** strains in host countries. Because of the increasing spread of HIV subtypes across international boundaries, these data may have implications for developing HIV vaccines and for promptly detecting and treating different HIV strains worldwide.
- ***Gathering surveillance data on HIV/AIDS trends*** among sentinel groups, such as female sex workers, pregnant women, STD patients, injection drug users, and children, to target, develop, and evaluate new interventions.
- ***Monitoring the natural progression of HIV infection*** to shed light on how to improve survival and quality of care for HIV-infected people, thus diminishing the personal and societal costs of the epidemic.
- ***Investigating risk factors***, including other diseases (e.g., STDs and tuberculosis), associated with HIV infection to identify links between these illnesses and to develop effective treatment strategies that can be applied globally.
- ***Investigating factors associated with heterosexual transmission of HIV.*** Worldwide, more people have been infected through heterosexual contact than any other exposure. And in the United States, heterosexual transmission accounts for a growing percentage of both HIV infections and AIDS cases. Understanding the biomedical and behavioral aspects of heterosexual transmission is key to containing HIV in this country and around the world.

Compendium of HIV Prevention Interventions with Evidence of Effectiveness

*from
CDC's HIV/AIDS Prevention
Research Synthesis Project*

November 1999

Compendium of HIV Prevention Interventions with Evidence of Effectiveness

from
**CDC's HIV/AIDS
Prevention Research Synthesis Project**

**Centers for Disease Control and Prevention
National Center for HIV, STD, and TB Prevention
Division of HIV/AIDS Prevention - Intervention Research and Support
Atlanta, Georgia**

November 1999

Acknowledgments

Many individuals, groups, organizations, and communities contributed to this *Compendium*. We are most grateful to those who participated in the research studies. They trusted that their time and effort in a study would increase our understanding about ways to prevent HIV/AIDS. We hope this document confirms their trust and supports their prevention goals.

Similarly, we thank the researchers who designed the interventions and carried out the studies. In the course of writing this document, we spoke with many of the original researchers. Their contact information throughout the *Compendium* underscores their continued commitment to HIV/AIDS prevention.

For the selection of effective interventions by applying consistent criteria, thanks to John Anderson, Wayne D. Johnson, Linda Kay, Mary Neumann, Salaam Semaan, and Ellen Sogolow of the Centers for Disease Control and Prevention (CDC); Don Des Jarlais of Beth Israel Medical Center; and Larry Hedges of the University of Chicago. For reviews of drafts and comments that improved the final document, thanks to Amy DeGroat, Nikki Economou, Michele Evering-Watley, Dorothy Gunther, Lynn Meinor, John Peppert, Laretta Pinckney, Tamara Sloan-Anderson, Kathy Stark, Chris Tullier, Duane Wilkerson, and Mary Willingham.

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November

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¹ACDP and Magura include multiple target populations, however; their summaries appear only once.

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Introduction

The Centers for Disease Control and Prevention (CDC) developed this *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* to respond to prevention service providers, planners, and others who request science-based interventions that work. All interventions selected for this *Compendium* came from behavioral or social studies that had both intervention and control/comparison groups and positive results for behavioral or health outcomes. We required designs with control/comparison groups so that successful results could be attributed to the interventions. Appendix A describes in detail the criteria used to select the interventions. This document provides *Summaries* of each intervention that met all criteria. These are referred to as effective interventions. To meet the ongoing need for current information about what works in HIV prevention, this *Compendium* will be updated approximately annually.

The *Compendium* provides state-of-the-science information about interventions with evidence of reducing sex- and/or drug-related risks, and the rate of HIV/STD infections. These interventions have been effective with a variety of populations, e.g., clinic patients, heterosexual men and women, high-risk youth, incarcerated populations, injection drug users, and men who have sex with men. They have been delivered to individuals, groups, and communities in settings such as storefronts, gay bars, health centers, housing communities, and schools.

A reader may want to consider an entire group of studies, for instance, all studies that used small group interventions. Table 1 highlights population and intervention characteristics for each of the interventions. Accessing additional materials may assist in implementing a selected intervention. Table 2 indicates the interventions that are part of CDC's Replicating Effective Programs (REP) and Research to Classroom: Programs That Work (PTW) projects. These ongoing projects support development of intervention materials, training, and technical assistance.

Once an intervention is adopted, its actual impact will depend on how it is implemented. The important thing is to achieve a balance between adapting the intervention to suit local needs and maintaining the core elements and key characteristics that made the original intervention successful. Also, the agency that implements the intervention will require organizational support, adequate staffing, and sufficient resources for implementation.

Finally, some readers may prefer an alternative or additional approach. They may want to assess and strengthen their existing program activities rather than select a new intervention, or to do both. We offer an Intervention Checklist to guide this process. The items on the Checklist are derived from many successful prevention interventions.

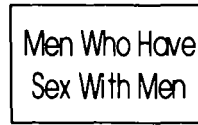
How the *Compendium* Is Organized

The *Compendium* is organized into four sections:

Section One: Summaries of Prevention Interventions

This section provides "one-pagers" or *Summaries* of each effective intervention. These are written to emphasize the intervention content and methods, based on information provided in the report.

Summaries are grouped by target populations:



Within groups, *Summaries* are ordered alphabetically by author.

Section Two: Tables

For all interventions, *Table 1* highlights characteristics of the populations and interventions.

For selected interventions, *Table 2* provides information about access to intervention materials.

Section Three: Intervention Checklist

The *Intervention Checklist* is a tool for intervention assessment. It is designed to clarify aspects of existing interventions that can be strengthened.

Section Four: Appendices

Appendix A describes CDC's Prevention Research Synthesis (PRS) project, the criteria used to select PRS primary studies, and the additional criteria used to select a subset of primary studies for the *Compendium*.

Appendix B contains the bibliography, which references each study in the *Compendium*, along with additional or supplemental citations that pertain to that study.

Summary Format

Section 1. Summaries of HIV Prevention Interventions uses a standard format, with the same elements used to describe each intervention. If an element is missing from a *Summary*, it is because the source citation does not contain that information. The following elements comprise the format:

Title, authors, reference -	bibliographic information for the source report (usually a journal publication, but may be "in press" or "submitted for publication")
Intervention goal(s) -	selected behavioral/health aims of the intervention (most often other aims exist but are outside the scope of the <i>Summary</i>)
Intervention setting -	the type of place in which the intervention was conducted
Population -	includes the following features:
<i>sample size</i> -	the number of people who participated (usually the total number in the intervention and control conditions of the study at baseline)
<i>demographics</i> -	selected characteristics of the participants (e.g., gender, race/ethnicity, age, education, income)
Comparison condition -	describes briefly what was provided to participants who did not receive the intervention during the study (e.g., a non-HIV intervention, usual HIV services such as HIV education and HIV counseling and testing)
Intervention description -	includes the following features:
<i>theory/model</i> -	the basis for the design of the intervention, which explains the behavior change
<i>duration</i> -	the length and number of intervention sessions
<i>location</i> -	where the intervention was carried out
<i>characteristics of facilitators/leaders</i> -	e.g., gender, race/ethnicity, age
<i>content</i> -	e.g., topics, information, skills pertaining to risk reduction
<i>method(s)</i> -	how the intervention was delivered or conducted
<i>handout(s)</i> -	materials given to participants
<i>incentives</i> -	cash/items used to encourage or support participation
Findings -	selected behavioral or health outcomes (usually at three or six months after intervention)
Contact person -	the research scientist (or designee) who conducted the intervention and/or its evaluation

¹ACDP and Magura include multiple target populations, however; their summaries appear only once.

Community-level HIV Intervention in Five Cities Final Outcome Data from the CDC AIDS Community Demonstration Projects

AIDS Community
Demonstration Projects
Research Group (1999)

*American Journal of
Public Health*, 89 (3), 336-
345

Description of Intervention: AIDS Community Demonstration Project

This community-level intervention was based on the Transtheoretical Model of Behavior Change, which recognizes that change occurs in stages. The intervention aimed to modify attitudes and beliefs about prevention methods among the community members by providing models of successful risk-reduction strategies adopted by members of the target population. The intervention took place over 3 years in Dallas, Denver, Long Beach, New York City, and Seattle. Peer volunteers from each target community were trained to carry out the intervention, drawing attention to and reinforcing identification with and acceptance of the intervention messages.

The intervention featured role model stories developed from the real-life experiences of local community members. These stories depicted members of the target population moving from earlier to later stages of change. Stories were developed and selected so that the majority matched the predominant stages of change and beliefs about condoms and bleach observed in the population.

The role model stories were featured in flyers distributed with condoms and bleach kits by the peer volunteers.

Intervention Goal(s): To determine the effects of a community-level intervention to increase condom use with main and non-main partners and/or to increase disinfection of injection equipment.

Intervention Setting: Street settings, public sex environments, and other community venues.

Population: Interviews were conducted with 15,205 individuals who were injection drug users, female sex partners of injection drug users, commercial sex workers, non-gay-identified men who have sex with men, high-risk youth, and/or residents in census tracts with high rates of sexually transmitted disease. Of the interviewees, 46% were men and 54% were women; 54% were African American, 19% were Hispanic, 22% were white, and 5% were of other racial/ethnic groups; and 35% were under 30 years of age.

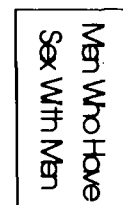
Comparison Condition: Usual HIV prevention activities and services available in the community.

Behavioral/Health Findings: Individuals in the intervention communities demonstrated significantly greater achievement of consistent condom use and maintenance of consistent condom use with non-main partners than individuals in the comparison communities.

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AIDS and the Transition to Illicit Drug Injection Results of a Randomized Trial Prevention Program

Description of Intervention: AIDS/Drug Injection Prevention

This prevention program was based on social learning principles. The intervention was delivered in four 1- to 1½-hour sessions over a 2-week time period. The intervention was led by 2 trainers who encouraged a therapeutic atmosphere in which participants felt free to discuss personal problem situations and seek help from the trainers and from their peers. Reduction in non-injected use of illicit drugs was an additional goal of the program. Trainers were clear not to take a condemning/punitive attitude. The emphasis was on recognizing and admitting problems with illicit drug use and then seeking treatment to reduce/eliminate the illicit drug use.

The four sessions covered understanding AIDS, risks of drug use and drug injection, sexual behavior and AIDS, and seeking entry into drug abuse treatment programs. The trainers used presentations, group discussion, and role-play of critical situations like refusing an offer of injection or seeking entry into a treatment program when one's non-injection drug use becomes too heavy.

Des Jarlais, D.C., Casriel,
C., Friedman, S.R.,
Rosenblum, A. (1992).

*British Journal of
Addiction* 87 (3), 493-498

Intervention Goal(s): To

determine the effects of a small group intervention to prevent the transition from sniffing heroin to injecting heroin.

Intervention Setting: Community storefront.

Population: Of the 83 drug users (heroin sniffers) who participated in the study, 69% were men and 31% were women; 23% were African American, 26% were Hispanic, and 51% were white. The average age of the participants was 28 years.

Comparison Condition: AIDS information and HIV antibody pretest counseling (HIV test optional).

Behavioral/Health Findings: Men and women who participated in the intervention were significantly less likely to inject drugs than those in the comparison condition.

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15-month Follow-up of Women Methadone Patients Taught Skills to Reduce Heterosexual HIV Transmission

El-Bassel, N., & Schilling, R.F. (1992).

Public Health Reports 107 (5), 500-504

Intervention Goal(s): To determine the effects of a small group intervention to reduce sexual risk behavior and HIV transmission by increasing AIDS knowledge, sexual negotiation skills, and safer sex practices.

Intervention Setting: Methadone maintenance clinics.

Population: Of the 84 female methadone patients who participated in the study, 36% were African American and 64% were Hispanic. More than 90% of the women were between the ages of 21 and 42 and 90% were unemployed.

Comparison Condition: HIV/AIDS information only.

Behavioral Findings:

Women who participated in the intervention significantly increased frequency of condom use with their partners compared with women in the comparison condition.

Contact:

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622 West 113th Street
New York, NY 10025

Description of Intervention: Skills Building

The intervention was delivered in five 2-hour sessions with about ten women in each group. The intervention was led by experienced female drug counselors who had received an additional 20 hours of training.

Sessions 1-2: Information on AIDS transmission and prevention. Trainers used video, other visual presentations, and didactic exercises to enable participants to identify their own high-risk sexual behaviors and barriers to adopting safer sex practices.

Session 3: Condom use. Members discussed their negative associations with condoms, practiced condom skills, and role-played scenarios that involved asking their partners to use condoms.

Sessions 4-5: Assertiveness training, problem solving, and communication skills. Participants practiced and personalized these skills, first by role-playing in scripted scenarios, then by selecting scenarios that reflected their own life.

Incentives included modest payments for attending the sessions.



Outcomes of Intensive AIDS Education for Male Adolescent Drug Users in Jail

Magura, S., Kang, S.,
Shapiro, J.L. (1994).

*Journal of Adolescent
Health, 15 (6), 457-463*

Intervention Goal(s): To
determine the effects of a
small group intervention to
reduce HIV drug- and sex-
related risk behaviors.

Intervention Setting: A
detention center.

Population: Of the 157
incarcerated, young, male
drug users who
participated in the study,
65% were African
American, 33% were
Hispanic, and 2% were
white. Median age was 18
years, ranging from 16 to
19 years.

Description of Intervention: Intensive AIDS Education in Jail

The intervention was based on a problem solving therapy model. It consisted of four 60-minute sessions focusing on health education issues relevant to male adolescent drug users, with emphasis on HIV/AIDS. The intervention was delivered at the New York City Department of Corrections Adolescent Reception and Detention Center on Rikers Island. Sessions used interactive methods and a small group format with 8 adolescents and one male counselor. Counselors were guided by a written curriculum.

Topics included general health knowledge, HIV and AIDS knowledge, factors associated with initiation and continuance of drug abuse, types of sexual behavior and HIV risk, the relationship of drug use and sexual behavior, and strategies to access services and drug abuse treatment in the community. Counselors adapted topics to the needs of the participants.

Counselors used techniques based on the problem-solving therapy model:

- *Problem orientation* - group members share and discuss facts and beliefs about HIV/AIDS
- *Problem definition and formulation* - members define specific high-risk attitudes and behaviors that must be modified to protect themselves and others against HIV/AIDS
- *Generation of alternative solutions* - members suggested and compiled possible courses of action for risky behaviors
- *Decision-making* - members critiqued and evaluated the alternative solutions
- *Solution implementation* - participants used role play and rehearsal techniques to practice alternative solutions.

The young men received \$5 for each group session they attended.

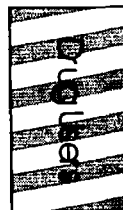
Comparison Condition: The intervention was given to comparison participants at a later time.

Behavioral Findings: After release from jail, youth who participated in the intervention were significantly more likely to use condoms during vaginal, oral, and anal sex and had fewer high-risk sex partners than youth in the comparison condition.

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E-mail: steve.magura@ndri.org



AIDS Education for Drug Abusers Evaluation of Short-term Effectiveness

McCusker, J., Stoddard,
A.M., Zapka, J.G.,
Morrison, C.S., Zorn, et al.
(1992).

*American Journal of
Public Health*, 82 (4),
533-540

Intervention Goal(s): To
determine the effects of
small group Informational
and Enhanced Education
interventions on drug- and
sex-related HIV risk
behaviors.

Intervention Setting: Inpatient drug detoxification and rehabilitation center.

Population: Of the 567 adult drug users who participated in the study, 67% were men and 33% were women; 81% were white; and 70% were high school graduates.

Comparison Condition: Essential HIV/AIDS information, using primarily didactic methods.

Behavioral Findings: After exit from the program, participants in both interventions reported significant reductions in drug- and sex-related risk behaviors compared with their baseline level of risk. For two behaviors, drug injection and cocaine use, the Enhanced Education intervention had significantly greater effects than the Informational Education intervention.

Contact:

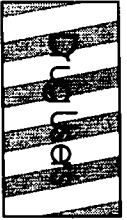
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Description of Intervention: Informational and Enhanced AIDS Education

The interventions drew primarily from Social Cognitive Theory and Relapse Prevention Theory, and also included concepts from the Health Belief Model and Theory of Reasoned Action. The Informational Education intervention consisted of two sessions. The Enhanced Education intervention was delivered in six sessions. When the six sessions were completed, participants received a 30-minute individual health education consultation.

The Informational Education intervention provided the essential HIV/AIDS information (prevention, transmission, etc.), using primarily didactic methods including video, lecture, discussion, homework, and demonstration (but not practice) of condom use and cleaning of drug paraphernalia.

The Enhanced Education intervention focused on personal susceptibility, situation analysis and skills building. Participants engaged in group discussions and practiced skills they could use to reduce risk in various situations. Additional strategies were homework assignments, tension-release exercises, role-playing, trigger tapes, peer feedback, and needle cleaning and condom skills exercises. Emphasis was placed on experiential learning techniques for the purpose of enhancing participants' self-efficacy regarding



Condom Skills Education and Sexually Transmitted Disease Reinfection

Cohen, D., Dent, C.,
MacKinnon, D. (1991).

Journal of Sex Research,
28 (1), 139-144

Intervention Goal(s): To
determine the effects of a
small group intervention on
the incidence of sexually
transmitted diseases
(STDs).

Intervention Setting: Waiting room of an STD clinic.

Population: Of the 192 adults who participated in the study, 59% were male and 41% were female; 67% were African American, 14% were Hispanic, and 19% were of other racial/ethnic groups. The median age of the participants was 25 years, ranging from 15 to 61 years.

Comparison Condition: Usual services available in the STD clinic.

Behavioral/Health Findings: Men and women who participated in the intervention were significantly less likely to return to the STD clinic within the next 12 months with a new STD than those in the comparison condition.

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Description of Intervention: Condom Skills Education

This intervention was based on the premise that familiarity with condoms and skills in using condoms properly are necessary for increasing future condom use. The intervention consisted of a brief condom skills education session led by a health educator who was an African-American woman. The intervention was delivered in a single 30-minute group session to people waiting for appointments in a Los Angeles STD clinic.

The session began with a 10- to 15-minute presentation in which the health educator emphasized 3 important points for effective condom use: condoms should be made of latex, condoms should have a reservoir tip or space left at the end, and condoms should be lubricated with a spermicide. The session included group discussion of how condoms should be used and a demonstration of how to put on a condom. The health educator referred to a poster that displayed a variety of condoms with their packaging. The presentation was followed by a 10- to 15-minute question-and-answer session.

Group Counseling at STD Clinics to Promote Use of Condoms

Cohen, D.A., MacKinnon,
D.P., Dent, C., Mason, H.,
Sullivan, E. (1992).

Public Health Reports, 107
(6), 727-730

Intervention Goal(s): To
determine the effects of a
small group intervention to
promote safer sex and condom use.

Intervention Setting: Waiting room of an STD clinic.

Population: Of the 426 adults who participated in the study, 71% were men and 29% were women; 83% were African American. The average age of the participants was 28 years.

Comparison Condition: Usual services available in the STD clinic.

Behavioral/ Health Findings: Men who participated in the intervention had a significantly lower STD reinfection rate than men in the comparison condition. There was no evidence of change for women.

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Description of Intervention: Group Discussion Condom Promotion

This intervention used the social context of small groups to encourage change in norms, expectations, and social skills. The intervention was delivered in a single group session to people waiting for appointments in a Los Angeles STD clinic. A trained female African-American health educator led sessions for groups of 10-25 participants.

The intervention session began with a video, "Let's Do Something Different," depicting condom use as socially acceptable. After the video a health educator facilitated a group discussion on methods of preventing STDs and promoting condom use. This discussion included the reasons why people liked and disliked condoms. Role-playing gave the clinic patients an opportunity to practice condom negotiation, first with the health educator and then with another patient. Questions relating to medical aspects of STDs were referred to clinic nursing and medical personnel. All participants were offered 10 free condoms by clinic nurses.

Heterosexual
Adults

Randomized Controlled Trial in an HIV Sexual Risk-reduction Intervention for Young African- American Women

DiClemente, R.J., &
Wingood, G.M. (1995).

*Journal of the American
Medical Association* 274
(16), 1271-1276

Intervention Goal(s): To
determine the effects of a
small group intervention to
increase consistent condom
use and prevent HIV
infection.

Intervention Setting: Community center.

Population: Among the 128 sexually active African-American women from an economically disadvantaged neighborhood who participated in the study, the average age was 23 years, ranging from 18-29 years.

Comparison Condition: The intervention was given to comparison participants at a later time.

Behavioral/Health Findings: Women who participated in the intervention were significantly more likely than women in the comparison condition to report consistent condom use with their partners, negotiating condom use, and not having sex when a condom was not available.

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Description of Intervention: Social Skills Training

Social Cognitive Theory and theories of gender and power were used as models to guide the development of this social skills intervention. The intervention consisted of five weekly 2-hour group sessions led by trained African-American peer educators in the Bayview-Hunter's Point community of San Francisco, California. Each session had a specific topic and planned activities for modeling and assessing skills.

Session 1: Gender and ethnic pride. The women discussed positive attributes of being an African-American woman.

Session 2: Personal responsibility for sexual decision making. The women watched an HIV prevention video and had discussion.

Session 3: Sexual assertiveness and communication training. Role-playing exercises were used to practice managing risky sexual situations.

Session 4: Condom use. The women concentrated on building skills and changing social norms for proper condom use.

Session 5: Cognitive coping skills. Participants developed skills such as sexual self-control.

Reducing Inner-city Women's AIDS Risk Activities: A Study of Single Pregnant Women

Hobfoll, S.E., Jackson, A.P., Lavin, J., Britton, P.J., Shepherd, J.B. (1994).

Health Psychology, 13 (5), 397-403

Intervention Goal(s): To determine the effects of a small group intervention to enhance AIDS knowledge, attitudes, and skills and, as a result, to influence behavior change.

Intervention Setting: Inner-city clinics for low-income women.

Population: Of the 206 single pregnant women who participated in the study, 57% were African American, 40% were white, and 3% were of other racial/ethnic groups. The average age of the participants was 21 years, ranging from 16 to 29 years. About one-third of the participants had not completed high school; 75% had income of less than \$10,000 per year.

Comparison Conditions: One was no intervention and the other was health promotion.

Behavioral Findings: Women who participated in the intervention increased their use of condoms with their partners significantly more than women in the comparison condition who received no intervention.

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Description of Intervention: Reducing AIDS Risk Activities

The intervention was based on theories of social learning, conservation of resources (including coping strategies and support skills), and communal support.

Clinics were in a mid-sized Midwestern city. The intervention consisted of 4 sessions, 1½- to 2-hours each, for groups of 2 to 8 women. Trained group leaders were female psychologists and health educators whose ethnic backgrounds were similar to those of the participants.

Sessions featured videos using actors from the target population illustrating assertiveness, negotiation skills, planning skills, and specialized skills (e.g., cleaning drug works). Women discussed the videos and role-played risk scenarios. Participants created health plans.

Women learned negotiation skills and assertiveness skills. They developed a sense of mastery and positive expectations of success. The sessions also included an activity in which women imagined an unhealthy behavior and then imagined a healthy behavior. The final session addressed relapse prevention.

Incentives included cash, partial reimbursement for transportation and child care costs, and participation in a lottery for a color television.

Efficacy of Risk-reduction Counseling to Prevent Human Immunodeficiency Virus and Sexually Transmitted Disease: A Randomized Controlled Trial

Kamb, M.L., Fishbein, M., Douglas, J.M., Rhodes, F., Rogers, J. et al., for the Project RESPECT Study Group. (1998).

Journal of the American Medical Association 280 (13), 1161-1167

Intervention Goal(s): To determine the effects of enhanced and brief interactive counseling interventions to reduce high-risk behavior and to prevent new STDs.

Intervention Setting: Inner-city STD clinics.

Population: Of the 5,758 HIV-seronegative adults who participated in the study, 57% were male and 43% were female; 59% were African American, 19% were Hispanic, 16% were white, and 6% were of other racial/ethnic groups. Median age of the participants was 25 years and 24% were < 20

Comparison Condition: Didactic messages typical of current care.

Behavioral Findings: Participants in both counseling interventions reported significantly higher condom use compared with participants in the comparison condition. Of the counseling participants, 30% fewer had new STDs compared with participants in the didactic message condition. In the counseling interventions, benefits accrued equally to men and women, and STD reduction was higher among adolescents than older participants.

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Description of Intervention: Project RESPECT

The Enhanced and Brief Counseling interventions were based on the Theory of Reasoned Action and Social Cognitive Theory. Sessions were interactive and designed to change factors that could facilitate condom use, such as self-efficacy, attitudes, and perceived norms. The study was conducted in Baltimore, Denver, Long Beach, Newark, and San Francisco. Health department staff, trained to conduct HIV counseling, delivered the intervention.

The Enhanced Counseling intervention consisted of 4 sessions, a total of 200 minutes, and was completed in 3-4 weeks.

Session 1: Assessed personal risk, identified barriers to risk reduction, and negotiated a small risk-reduction step achievable in the next week.

Session 2: Explored condom use attitudes, discussed prior week's behavior change successes and barriers, and devised a strategy for taking a risk-reduction step before the next session.

Session 3: Built condom use self-efficacy, discussed prior week's behavioral goal and barriers and facilitators to condom use, and devised a strategy for taking another risk-reduction step.

Session 4: Explored social norms and support for condom use, discussed prior week's behavioral goal successes and barriers, and devised a long-term strategy for consistent condom use.

The Brief Counseling intervention consisted of 2 sessions, a total of 40 minutes, and was completed in 7-10 days. It was based on the HIV Prevention Counseling recommended by CDC for use with HIV testing since 1993.

Session 1: Identical to Session 1 above.

Session 2: Received HIV test results, discussed changes, support for changes made, and barriers and facilitators to change, and developed a long-term plan

This study meets CDC's Prevention Research Synthesis project criteria for relevance and methodological rigor and also

The Effects of HIV/AIDS Intervention Groups for High- risk Women in Urban Clinics

Kelly, J.A., Murphy, D.A.,
Washington, C.D., Wilson,
T.S., Koob, J.J., et al.,
(1994).

*American Journal of
Public Health, 84 (12),
1918-1922*

Intervention Goal(s): To
determine the effects of a
small group intervention on
high-risk behaviors.

Intervention Setting:
Inner-city health clinic.

Population: Of the 197 women who participated in the study, 87% were African American, 3% were Hispanic, 4% were American Indian, and 6% were white. The average age of participants was 29 years, and 97% of the whole group was unemployed. Average education level was some high school.

Comparison Condition: Family and child nutrition intervention.

Behavioral Findings: Women who participated in the intervention reported a significantly greater increase in condom use with their partners and a significantly greater decrease in their frequency of engaging in unprotected sex than women in the comparison condition.

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Description of Intervention: Cognitive-Behavioral Skills Training Group

The intervention incorporated cognitive-behavioral and risk-reduction skills training principles and peer support elements. It consisted of 4 weekly group sessions, 90 minutes each. There were 8 to 10 women in each group. The sessions were conducted in Milwaukee, Wisconsin by 2 female group leaders.

The sessions provided detailed information about HIV risk and focused on behaviors that increase risk, common misconceptions about AIDS, and steps to reduce the risk of contracting the disease. National and local HIV seroprevalence and epidemiology statistics were summarized to personalize risk situations for the women, including the possibility of encountering an infected partner.

Exercises emphasized cognitive-attitudinal areas, behavioral skills, and social factors. Participants role-played initiating discussion of concerns about AIDS and condom use with potential sex partners and resisting sexual pressure from a man whose risk history was unknown or with whom the woman did not want to have sex.

Skills-building was a critical component of this intervention. Condom demonstration and practice were provided to desensitize participants to condom use. Also, attention was directed toward recognizing, understanding, and managing one's personal triggers for high-risk behavior.

Heterosexual
Adults

A Community-level HIV Intervention for Inner-city Women: Results of the Women and Infants Demonstration Trial

Lauby, J.L., Smith, P.J., Stark, M., Person, B., Adams, J. (1998). Philadelphia, PA

Philadelphia Health Management Corporation.

Intervention Goal(s): To determine the effects of a community-level intervention to increase condom use with main and non-main partners.

Intervention Setting: Street settings, community agencies, organization, businesses, residential complexes, and other community settings.

Population: Interviews were conducted with 3,725 sexually active women of reproductive age in four matched pairs of inner-city communities. In this group of women, 73% were African American, 20% were white, and 7% were of other racial/ethnic groups; mean age was 25 years.

Comparison Condition: Usual HIV prevention programs available in the community.

Behavioral/Health Findings: Women in the intervention communities reported a greater increase in consistent condom use with non-main partners than women in the comparison communities.

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Description of Intervention: Real AIDS Prevention Project (RAPP)

This community-level intervention was based on the Transtheoretical Model of Behavior Change, which recognizes that change occurs in stages. The intervention aimed to modify attitudes and beliefs about prevention methods among the community women by providing models of successful risk-reduction strategies adopted by members of the target population. The intervention included 3 components: a media campaign, outreach, and community mobilization. The media campaign included frequent distribution of flyers, brochures, posters, and newsletters that told "role model" stories based on the lives of women in the local community, contained HIV prevention material and referral sources, and furnished other information related to women's physical, social, and economic well-being. The role model stories presented readable and realistic accounts of women in different degrees of readiness to use condoms (i.e., stage-based stories) with either main or non-main partners, how they had overcome barriers or had learned from experience about the need to use condoms, and how they had progressed to more consistent condom use. Media pieces were distributed hand-to-hand or were left at drop sites in businesses, agencies, and meeting places throughout the target communities.

Stage-based outreach was implemented by women from the communities who were either paid a stipend or employed by the project. Outreach was usually one-on-one but was sometimes delivered to groups. The purpose of these interpersonal contacts was to present HIV information and referrals, encourage and reinforce behavior change, and distribute condoms and role model stories.

Community mobilization entailed the recruitment of small businesses, neighborhood organizations, and agencies to donate services or products and to function as sites for distributing role-model stories and displaying posters and other visual materials.

Reductions in STD Infections Subsequent to an STD Clinic Visit

O'Donnell, C.R.,
O'Donnell, L., San Doval,
A., Duran, R., Labes, K.
(1998).

Sexually Transmitted Diseases, 25 (3), 161-68

Intervention Goal(s): To determine the effects of a small group intervention to reduce sexually transmitted disease (STD) infections subsequent to a clinic visit.

Intervention Setting: STD clinic.

Population: Of the 2004 adult males who participated in the study, 62% were African American and 38% were Hispanic. The average age of the participants was 30 years.

Comparison Condition: Usual services available in the STD clinic.

Behavioral Findings: Men who participated in the intervention had a significantly lower rate of new STD infection than men in the comparison condition.

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Description of Intervention:

Video Opportunities for Innovative Condom Education and Safer Sex (VOICES/VOCES)

All participants received STD prevention information, individual counseling, free condoms, and a coupon for condoms as part of their clinic visit for diagnostic and treatment services.

The video-based intervention consisted of a 60-minute session in which participants viewed a 20-minute culturally sensitive video and engaged in a facilitated interactive group discussion. The intervention was delivered to small groups of 3 to 8 men in an STD clinic in the South Bronx, New York City. A trained STD counselor led the discussions.

One video, "Let's Do Something Different," was designed for African Americans and another, "Porque Si," was developed for Hispanics. Both videos provided accurate risk information and corrected misinformation, portrayed positive attitudes about condom use, and modeled gender- and culturally-specific strategies for encouraging condom use. Interactive discussions following the videos aimed to reinforce the STD and HIV prevention messages. Participants addressed problems they had experienced when trying to use condoms and discussed strategies to increase condom use.

Participants were offered a selection of free condoms at the clinic and a coupon for free condoms at an area pharmacy.

Reduction of High-risk Sexual Behavior among Heterosexuals Undergoing HIV Antibody Testing: A Randomized Control Trial

Wenger, N.S., Linn, L.S., Epstein, M., Shapiro, M.F. (1991).

American Journal of Public Health, 81 (12), 1580-1585

Intervention Goal(s): To evaluate the effects of HIV education and testing on sexual risk behavior.

Intervention Setting: Urban Sexually Transmitted Diseases (STD) clinic.

Population: Of the 186 heterosexual adults who participated in the study, 67% were men and 33% were women; and 88% were African American; 84% had completed high school; and 43% were unemployed. The average age was 28 years, ranging from 18 to 66 years.

Comparison Condition: HIV education only.

Behavioral Findings: Participants who received the HIV education and testing intervention reported significantly fewer occurrences of unprotected intercourse than did those in the comparison condition.

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Description of Intervention: HIV Education, Testing and Counseling

The intervention was offered to clients of an STD clinic in Los Angeles.

The intervention consisted of an educational component and an HIV blood test. The educational component included (a) a written pamphlet that explicitly discussed safer and unsafe sexual acts and explained condom use; (b) a 15-minute video that examined HIV-risk behavior and promoted condom use as well as discussing the risk with sex partners; and (c) a 10-minute, one-on-one counseling session with a physician. The counseling session focused on assessing personal risk, discussing the elements of HIV testing, and answering any questions about HIV/AIDS or testing. [NOTE: See *Summary* for Kamb, et al. for current HIV testing and counseling protocols.]

After completing the educational module, intervention participants had blood drawn for an HIV test. Test results were revealed to intervention participants approximately 2 weeks after study entry and were accompanied by the same risk-reduction message as during the pretest counseling (for seronegative results) or in-depth counseling (for seropositive results).

Heterosexual
Adults

The Mpowerment Project: A Community-level HIV Prevention Intervention for Young Gay Men

Kegeles, S.M., Hays, R.B., Coates, T.J. (1996).

American Journal of Public Health, 86 (8), 1129-1136

Intervention Goal(s): To determine the effects of a community-level intervention to reduce HIV risk behaviors.

Intervention Setting: Mpowerment Center and other community venues where gay men congregated.

Population: Of the cohort of 300 young gay men who were evaluated after 8 months of study, 4% were African American, 7% were Asian or Pacific Islander, 81% were white, and 2% were of other racial/ethnic groups. The average age of the men was 23 years, and the median education level was some college.

Comparison Condition: The intervention was given to comparison communities at a later time.

Behavioral Findings: Men who participated in the Mpowerment Project reduced their frequency of unprotected anal intercourse significantly more than the men in the comparison community.

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Description of the Intervention: Mpowerment Project

This intervention was based on theories of peer influence and diffusion of innovations, which posit that people are most likely to adopt new behaviors when favorable evaluations of the behavior are conveyed to them by similar others whom they respect. The intervention was conducted over 8 months and attempted to reach all young gay men in a Eugene, Oregon community.

A Core Group of young gay men designed and ran the intervention with input from a Community Advisory Board composed of "elders" from the AIDS, public health, gay and lesbian, and university communities. This engendered a personal commitment to HIV prevention, a sense of ownership of the prevention activities, and a willingness to carry out the activities.

This multi-component intervention included 2 types of formal outreach, informal outreach, peer-led small groups and a small publicity campaign. One type of formal outreach activity was directed at venues where young gay men congregated. Volunteers dressed in costumes and distributed safer-sex materials. Another type of formal outreach activity took place at the Mpowerment Center. It consisted of safer-sex promotional events embedded in a series of fun social activities. Informal outreach consisted of peer-initiated communications among friends about the need for safer sex. Small groups, called M-Groups, lasted about 3 hours and were designed to be fun and interactive. They served as entry into the project, addressed safer-sex concerns and skills, and motivated participants to invite their friends. The small publicity campaign aimed to reinforce the norms for safer sex and spread awareness of the Mpowerment Project.

Men Who Have
Sex With Men

Behavioral Intervention to Reduce AIDS Risk Activities

Kelly, J.A., St. Lawrence,
J.S., Hood, H.V.,
Brasfield, T.L. (1989).

*Journal of Counseling and
Clinical Psychology*, 57
(1), 60-67

Intervention Goal(s): To
determine the effects of a
small group intervention to
reduce the frequency of
high-risk sexual practices
and increase behavioral
skills for refusing sexual
coercions.

Intervention Setting: An
office space associated
with a medical center.

Population: Of the 104 gay men who participated in the study, 13% were African American or Hispanic and 87% were white. The average age of the participants was 31 years; 45% had completed college.

Comparison Condition: The intervention was given to comparison participants at a later time

Behavioral Findings: Gay
men who participated in the intervention reduced their frequency of unprotected anal intercourse and increased their use of condoms significantly more than the men in the comparison condition.

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Description of Intervention: Behavioral Self-management and Assertion Skills

The intervention consisted of 12 weekly group sessions, each about 75 to 90 minutes. Groups were led by 2 clinical psychologists and 2 project assistants.

Sessions 1-2: AIDS risk reduction. This component included information about AIDS, HIV infection, and HIV-transmission methods.

Sessions 3-5: Behavioral self-management. Participants examined past high-risk sexual activity and identified mood, setting, substance use, and other factors associated with the risk taking. Leaders presented strategies to reduce risk.

Sessions 6-8: Assertion skills training. Three scenarios were used: (a) initiating discussion about one's commitment to low-risk behavior with a potential sex partner; (b) refusing pressures to engage in high-risk behavior; and (c) declining an immediate sexual proposition from a person one wanted to get to know socially.

Sessions 9-11: Relationship skills and social support development. This component addressed strategies for problem solving in relationships and for maintaining low-risk sexual practices, even in committed relationships.

Session 12: Risk-reduction review and identification of useful strategies. This session allowed each participant to address the changes he had made and the strategies he had used.

The intervention used group process, lecture, and role-playing methods to deliver information and develop skills.

Men Who Have
Sex With Men

Community AIDS/HIV Risk Reduction: The Effects of Endorsements by Popular People in Three Cities

Kelly, J.A., St. Lawrence, J.S., Stevenson, Y., Hauth, A.C., Kalichman, S.C., et al., (1992).

American Journal of Public Health, 82 (11), 1483-1489

Intervention Goal(s): To determine the effects of a community-level intervention to reduce high-risk behaviors.

Intervention Setting: Gay bars.

Population: Of the 1,469 gay men who completed anonymous baseline and post-intervention surveys in three cities, 9% were African American, 85% were white, and 5% were Hispanic or of other racial/ethnic groups. Average age was 29 years. From the same three cities, 75 gay men of similar race/ethnicity and age were trained as peer leaders.

Comparison Condition: The intervention was given to comparison participants at a later time.

Behavioral Findings: Men from communities that received the intervention reported a significantly greater reduction in unprotected anal intercourse than the men from the comparison communities.

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Description of Intervention: Popular Opinion Leader (POL)

This intervention was based on theories of peer influence, behavioral standards and social norms, and diffusion of innovations. Bartenders at gay clubs in Biloxi, Mississippi, Monroe, Louisiana, and Hattiesburg, Mississippi were enlisted to nominate opinion leaders, i.e., persons who were popular with others. The intervention was delivered in two parts:

Part I. Popular opinion leaders received four sessions, 90 minutes each, of HIV education and communication strategies. A male and a female co-facilitator conducted each session.

Session 1: Epidemiology of HIV, risk and protective behaviors, and misconceptions.

Session 2: Characteristics of effective health promotion messages. Facilitators described ways to sensitize others to the threat of AIDS, stressed that behavior change can prevent AIDS, used self as example, and personally endorsed the benefits of change.

Session 3: Conversational examples of effective health promotion messages. Facilitators modeled conversations and opinion leader participants role-played similar conversations.

Session 4: Real-life conversations and problem solving. Participants reported outcomes of actual conversations (see Part II). Facilitators helped them plan for additional peer conversations.

Part II. Each opinion leader agreed to have at least 14 conversations with peers in the bars about AIDS risk reduction. Opinion leaders wore buttons with a logo that promoted the project and matched posters located in the bars. Buttons were ambiguous and served to trigger conversations.

Men Who Have
Sex With Men

AIDS Prevention in Homosexual and Bisexual Men: Results of a Randomized Trial Evaluating Two Risk-Reduction Interventions

Valdiserri, R.O., Lyter,
D.W., Leviton, L.C.,
Callahan, C.M., Kingsley,
et al., (1989). *AIDS*, 3 (1),
21-26

Description of Intervention: Small Group Lecture Plus Skills Training

The intervention consisted of a lecture and a skills training session delivered in a 2-session small group format in a community-based organization in Pittsburgh, Pennsylvania. The 60- to 90-minute lecture component, led by a gay health educator, reviewed HIV transmission and the clinical outcomes of HIV infection, the risks of specific sexual practices, the importance of risk reduction through safer-sex practices, correct condom use, and interpretation of HIV antibody tests.

The 140-minute skills-training session was led by a psychotherapist from a community organization that provides counseling services to sexual minorities. The skills-training session included role-playing, psychodrama, and group process to promote the social acceptability of safer sex; strategies to reduce sexual risk behavior; and group discussion on sexuality and relationships among gay men.

Men Who Have
Sex With Men

Intervention Goal(s): To determine the effects of an educational intervention program that included skills training in addition to a small group lecture on sexual risk and protective behaviors.

Intervention Setting: The office of a community-based organization.

Population: Of the 584 gay and bisexual men who participated in the study, 2% were African American, 95% were white, less than 1% were Hispanic, and less than 1% were Asian. The average age was 33 years, ranging from 19 to 73 years, and 33% of the participants had a college degree.

Comparison Condition: Small group lecture.

Behavioral Findings: Men who participated in the small group lecture plus skills training educational intervention showed a significant increase in condom use for insertive anal intercourse compared to those in the comparison condition.

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Reductions in HIV Risk-associated Sexual Behaviors among Black Male Adolescents: Effects of an AIDS Prevention Intervention

Description of Intervention: Be Proud! Be Responsible!

The intervention consisted of one 5-hour session held on a Saturday morning in a local school in Philadelphia, Pennsylvania. The session was led by African-American men and women with backgrounds in human sexuality education, nursing, social work, and small group facilitation. The leaders received 6 hours of training for this intervention. The intervention included information about risks associated with injection drug use and specific sexual activities. The intervention used videos, games, exercises, and other culturally and developmentally appropriate materials to reinforce learning and to encourage active participation.

For example, one video was narrated by an African-American woman and had a multi-ethnic cast.

In another activity, "AIDS Basketball," participants formed into teams to earn points for correctly answering factual questions on AIDS. In the exercise, "Uncle Bill's Advice Column," pairs of adolescents wrote a response to a letter to Uncle Bill about AIDS or risky behavior and then read it to the rest of the group for discussion.

A condom exercise focused on the correct use of condoms. The participants also engaged in role-playing situations depicting potential problems in trying to implement safer sex practices, including abstinence.

Jemmott, J.B., Jemmott, L.S., Fong, G.T. (1992).

American Journal of Public Health, 82 (3), 372-377

Intervention Goal(s): To determine the effects of a small group intervention to reduce HIV risk behaviors and increase condom use.

Intervention Setting: A local school on a Saturday.

Population: Of the 157 African-American male adolescents who participated in the study, the average age of participants was 15 years; almost all (97%) were enrolled in school.

Comparison Condition: Focused on careers.

Behavioral Findings: Adolescents who participated in the intervention reported more frequent use of condoms and fewer sex partners than adolescents in the comparison condition.

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Reducing the Risk: Impact of a New Curriculum on Sexual Risk-taking

Description of Intervention: Reducing the Risk

The intervention was based on social learning, social inoculation, and cognitive behavioral theories. The intervention was carried out in 13 high schools in California. Health education classes offered the 15-session intervention as part of the 10th grade comprehensive health curriculum. Teachers who volunteered to implement the intervention curriculum attended a 3-day training session.

The curriculum included instruction on developing social skills to reduce sexual risk-taking behavior and used role play as a means of practicing and modeling those skills. Numerous activities supported the norm that students should avoid unprotected intercourse, either by not having sex or by using contraceptives. Students repeatedly role played situations where they recognized various forms of social pressure to have sex, examined the "lines" that young people use to obtain sex, were motivated to resist these pressures, and practiced effective strategies and skills to refrain from sex or unprotected sex. Over the 15 weeks, role plays were less scripted and more oriented to developing student's confidence in their ability to resist pressure. The curriculum also emphasized decision making and assertive communication skills, encouraged students to go to stores and clinics to obtain relevant health information, and required students to ask their parents about their views on abstinence and birth control.

Kirby, D., Barth, R.P.,
Leland, N., Fetro, J.V.
(1991).

*Family Planning
Perspectives*, 23 (6),
253-263

Intervention Goal(s): To determine the effects of a classroom intervention to postpone initiation of sexual intercourse and, among those sexually experienced, to reduce unprotected sex.

Intervention Setting:
High school classrooms.

Population: Of the 758 students who participated in the study, 47% were male and 53% were female; 2% were African American, 2% were American Indian, 9% were Asian, 20% were Hispanic, 62% were white, and 5% were of other racial/ethnic groups; 56% were in 10th grade; and about 37% were sexually experienced prior to the study.

Comparison Condition: Usual sexuality instruction available in the school.

Behavioral Findings: Students receiving the intervention were significantly less likely to initiate sexual intercourse than those in the comparison condition; intervention students who were already sexually experienced were significantly less likely to engage in unprotected intercourse than sexually active students in the comparison condition.

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Preventing HIV Infection Among Adolescents: Evaluation of a School-based Education Program

Main, D.S., Iverson, D.C., McGloin, J., Banspach, S.W., Collins, J.L., Rugg, et al., (1994).

Preventive Medicine, 23 (4), 409–417

Description of Intervention: Get Real about AIDS©1992

This intervention was primarily based on Social Cognitive Theory and the Theory of Reasoned Action. The intervention was implemented in 10 schools in 6 Colorado school districts. The intervention consisted of a 15-session skills-based curriculum, based in part on the program Get Real About AIDS©1992. Most of the intervention teachers taught health; some taught science, physical education, and study skills. Teachers attended a 5-day (40 hours) training program designed to enhance relevant skills and fidelity of the implementation to the written curriculum.

The curriculum covered the following topics: HIV functional knowledge (that is, knowledge that can be used to reduce risk), teen vulnerability to HIV, normative determinants of risky behavior, condom use, and skills designed to help students recognize, manage, avoid, or leave risky situations.

Intervention Goal(s): To determine the effects of a classroom intervention to postpone the initiation of sexual intercourse and to reduce the number of students engaging in unsafe sex and drug-using behaviors.

Intervention Setting: High school classrooms.

Population: Of the 2,015 students who participated in the study, 51% were male and 49% were female; 6% were African American, 3% were Asian, 21% were Hispanic, 65% were white, and 5% were of other racial/ethnic groups. The average age of the students was 15 years; 60% were in the 9th grade; 44% were sexually experienced prior to the study.

Comparison Condition: Usual program, which was no HIV education or minimal HIV education, as determined by the school districts.

Behavioral Findings: Students who participated in the intervention reported fewer sex partners and greater frequency of condom use than students in the comparison schools.

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Reductions in HIV Risk among Runaway Youths

Rotheram-Borus, M., Van Rossem, R., Lee, M., Gwadz, M., Koopman, C. (1997)

University of California, Department of Psychiatry, Division of Social and Community Psychiatry, Los Angeles, CA

Intervention Goal(s): To determine the effects of a small group intervention to reduce HIV-related sexual and drug-related risk behaviors.

Intervention Setting: Shelters for runaway adolescents.

Population: Of the 312 runaway and homeless youths who enrolled in the study, 51% were male and 49% were female; 57% were African American, 22% were Hispanic, 16% were white or of other racial/ethnic groups, and race/ethnicity was unknown for 5%. The average age of the youths was 16 years.

Comparison Condition: Usual services available in the runaway shelters.

Behavioral Findings: Adolescents who participated in the intervention reduced both the number of unprotected sexual acts and their substance use significantly more than adolescents in the comparison shelters.

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Description of Intervention: StreetSmart

This intervention was based on Social Learning Theory, using small groups (a) as practice and role-play opportunities, (b) to mobilize and reinforce positive behaviors, and (c) to maintain support networks. The intervention consisted of 10 group sessions on a rotating basis, 3 times per week, repeated every 4 to 6 weeks, and one individual counseling session. Sessions were led by trained counselors in shelters for runaway youth in the New York City area. The intervention had four primary components:

1. HIV-related knowledge. Activities included video and art workshops where youth developed soap opera dramatizations, public service announcements, commercials, and raps about HIV prevention, and they reviewed and discussed commercial HIV/AIDS prevention videos.
2. Social skills. Training on assertiveness and coping skills, including use of a "feeling thermometer," were employed to develop skills for use in HIV-risk situations.
3. Access to resources. Participants visited a community-based comprehensive health and mental health center.
4. Personalized beliefs, attitudes and norms. Participants had a private counseling session during which they could assess individual barriers to practicing safer sex and discuss their own attitudes and behavior patterns. Dysfunctional attitudes and behavior patterns were targeted.

Incentives included food and \$1 for carrying condoms and arriving to the program on time.

A Randomized, Controlled Effectiveness Trial of an AIDS Prevention Program for Low- income African- American Youths

Description of Intervention: Focus on Kids

The intervention, developed through ethnographic research, targeted pre- and early-adolescents in their existing friendship groups. Being in such a group was a requirement of enrollment. AIDS prevention education was based on a social cognitive model, Protection Motivation Theory (PMT), that uses cost and reward constructs to explain how intentions are formed to respond to threats in either adaptive or maladaptive ways.

The intervention consisted of 8 sessions: seven 1½-hour weekly meetings at local recreational centers and one day-long session at a rural campsite. The intervention was delivered in a large Eastern city to peer groups that consisted of 3 to 10 same-gender friends within 3 years of age of each other. The sessions were led by a pair of interventionists, at least one of whom was gender matched to the group. Most of the interventionists were African-American men and women recruited from the community.

Each session focused on one or more PMT concepts and also reviewed concepts from the prior session. Beginning in the first session and integrated throughout, a family genogram was used to illustrate the application of concepts to real-life situations.

Sessions emphasized values clarification and goal setting; presented facts regarding AIDS, STDs, contraception, and human development; and provided condoms. Multiple delivery formats were used to address individual variability in receptivity to media, e.g., videos, games, role-playing, acting, storytelling, and arts and crafts.

In the seventh session, participants developed community projects with specific target audiences and intervention messages. The eighth session included a presentation of the projects and concluded with a "graduation" ceremony.

Stanton, B.F., Li, X.,
Ricardo, I., Galbraith, J.,
Feigelman, S., Kaljee, L.
(1996).

*Archives of Pediatrics and
Adolescent Medicine*, 150
(4), 363-372

Intervention Goal(s): To
determine the effects of a
peer network decision-
making intervention to
increase condom use
among sexually active
youth.

Intervention Setting:

Recreation centers
associated with public housing developments; rural campsite setting.

Population: Of the 383 African-American youths who participated in the study, 56% were male and 44% were female. The average age was 11 years, and 78% were aged 9 through 12 years; 36% were sexually experienced prior to the study.

Comparison Condition: Individual youth attended weekly sessions, which included a movie with AIDS facts, discussion, and access to condoms.

Behavioral Findings: Sexually active youth who participated in the intervention reported significantly greater condom use than sexually active youth in the comparison condition.

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Cognitive-Behavioral Intervention To Reduce African-American Adolescents' Risk for HIV Infection

St. Lawrence, J.S., Brasfield, T.L., Jefferson, K.W., Alleyne, E., O'Bannon, Shirley, A. (1995).

Journal of Consulting and Clinical Psychology, 63 (2), 221-237

Intervention Goal(s): To determine the effects a small group intervention.

Intervention Setting: A public health clinic serving low-income families.

Population: Of the 246 inner city African-American youths who enrolled in the study, 28% were male and 72% were female. The average age was 15 years, ranging from 14 to 18 years; the average school grade was 10; and 36% were sexually experienced prior to the study.

Comparison Condition: Received Session 1 only.

Behavioral Findings: Youths who participated in the intervention reported significantly greater condom use and significantly lower frequency of unprotected intercourse than youths in the comparison condition. Abstinent youth who participated in the intervention significantly delayed sexual onset to a greater extent than abstinent youth in the comparison condition.

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Description of Intervention: Becoming A Responsible Teen (BART)

This intervention is based on social learning theory and stresses attention to participants' informational needs, motivational influences, and behavior (IMB), from the IMB risk-reduction model. The intervention consisted of 8 weekly educational and behavior skills sessions of 90 to 120 minutes each. Two co-facilitators, a male and a female, led the sessions in a small group format. The intervention was conducted in a comprehensive health center that serves predominantly low-income minority clients in a Mississippi city of 400,000 residents.

Session 1: AIDS education. HIV/AIDS information, presented in the context of local HIV/AIDS demographics, was interspersed with games, group discussion, and other activities.

Session 2: Sexual decisions and values. Group discussion about sexual decisions and pressures was followed by a video for African-American youths, *Seriously Fresh*, and video discussion.

Session 3: Technical competency skills. Discussion of statewide adolescent sexual activity levels was followed by condom use demonstrations, small group practice, and cognitive restructuring of unhelpful beliefs about self-protection and condom use.

Session 4-6: Social competency skills. Communication skills and assertiveness were taught in 3 contexts: a) initiating discussion about condoms in advance with a sex partner, b) refusing pressure to engage in unprotected sex, and c) sharing HIV-risk information with peers. Leaders demonstrated these skills, followed by participant role play.

Session 7: Cognitive competency skills. Local HIV-seropositive youths, the "Rap Team," discussed how HIV had affected their lives. Behavioral self-management and problem-solving strategies, especially those used successfully in the past, were the focus of sessions 7 and 8.

Session 8: Social support and empowerment. Participants shared what each felt was most helpful in BART and the personal changes each had made in response to participating in BART. The impact the group could have by educating friends and families was illustrated and the importance of supportive friendship networks was stressed.

Incentives included \$5 an hour for participation, a project T-shirt for attending all sessions, and a personalized certificate of completion at the final

Section 2

Tables