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Table 1.

	POPULATION													INTERVENTION					
	Gender, Race/Ethnicity, and Age													Setting, Level, and Duration					
Citation	Target				Gender %		Race/Ethnicity %						Age (Yrs.)		Setting	Level			Duration (Sessions)	
	DU	HA	MSM	Y	M	F	A-A	API	H	AI	W	O	Aver.	Range		Ind	Grp	Com	Number	Min. Each
ACDP '99	▨	▒	▦	■	46	54	54		19		22	5		30% <30	Community	✔	✔	✔	Continu-ous-3yrs	N/A
Cohen '91		▒			59	41	76		15			9	25*	15-61	Clinic		✔		1	30
Cohen '92		▒			71	29	92 #						28		Clinic		✔		1	60
Des Jarlais '92					69	31	23		26		51		28		Storefront		✔		4	60-90
DiClemente '95		▒				100	100						23	18-29	Community		✔		5	120
El-Bassel '92	▨					100	36		64					90% 21-42	Clinic		✔		5	120
Hobfoll '94		▒				100	57				40	3	21	16-29	Clinic		✔		4	90-120
Jemmott '92				■	100		100						15		School		✔		1	300
Kamb '98		▒			57	43	59		19		16	6	25*	24% <20	Clinic	✔			Enha: 4 Brief: 2	Total 200 Total 40
Kegeles '96			▦		100		4#	7			81	2	23		Social Clubs		✔	✔	NA	NA
Kelly '89			▦		100		13				87		31		Med. Office		✔		12	60-90
Kelly '92			▦		100		9		5†		85		29		Gay Bars	✔	✔	✔	4	90
Kelly '94		▒				100	87		3	4	6		29		Clinic		✔		4	60-90
Kirby '91				■	47	53	2#	9	20	2	62			56% in 10th grade	School		✔		15	
Lauby '98		▒				100	73				20	7	25		Community	✔	✔	✔	Continu-ous-3 yrs	N/A
Magura '94	▨			■	100		65		33		2		18*	16-19	Prison		✔		4	60
Main '94				■	51	49	6	3	21		65	5	15		School		✔		15	
Youth '92	▨				67	33					81#		N/A		Drug Program		✔		5	60
O'Donnell '94		▒			100		62		38				30		Clinic		✔		1	60
Rotheram-Borus '97				■	51	49	57		22		16†	5‡	16		Shelter		✔		10	
Stanton '96				■	56	44	100						11	9-12	Community		✔	✔	7 1 retreat	90 all day
St. Lawrence '95				■	28	72	100						15	14-18	Clinic		✔		8	90-120
Valdiserri '89			▦		100		3	<1	1		95		33	19-73	CBO Office		✔		1	120-150
Wenger '92		▒			67	33	87#						28	18-66	Clinic		✔		1	60

DU = Drug Users; HA = Heterosexual Adults; MSM = Men who have Sex with Men; Y = Youth

A-A = African American; API = Asian / Pacific Islander; H = Hispanic; AI = American Indian; W = White; O = Other

Aver. = Average; Ind = Individual; Grp = Group; Com = Community; Min. Each = Minutes per session; CBO = Community-Based Organization; Med. = Medical; Enha = Enhanced; Stan = Standard

† Combined with 'Other' race/ethnicity; ‡ race/ethnicity unknown; # race/ethnicity not reported on 100% of the study population; *median age given instead of mean age

Table 2.

Interventions with CDC Support for Materials Production, Technical Assistance, and Training

Table 2 lists the studies that receive CDC support through either Replicating Effective Programs[1] (REP), in CDC's Division of HIV/AIDS Prevention or, for youth, Research to Classroom: Programs That Work (PTW), in CDC's Division of Adolescent and School Health. Since some of the REP and PTW studies were recently funded, some materials are not yet available.

Author of Study and Materials Developer	Intervention Name	Target Population	Original Funding Source	Materials Available
ACDP	AIDS Community Demonstration Project	All Categories	CDC	Yes$_3$
Kamb, 1998)	Project RESPECT	Heterosexual Adults	CDC	Yes$_B$
Lauby 1998 (materials by Adams)	Real AIDS Prevention Project (RAPP)	Heterosexual Adults	CDC	In Progress$_1$
O'Donnell, 1994	VOICES/VOCES	Heterosexual Adults	CDC	Yes$_1$
Kegeles, 1996	Mpowerment	Men Who Have Sex With Men	NIMH	In Progress$_1$
Kelly, 1992	Popular Opinion Leader (POL)	Men Who Have Sex with Men	NIMH	Yes$_1$
Jemmott, 1992	Be Proud! Be Responsible!	Youth	NIMH	Yes$_2$
Kirby, 1991	Reducing the Risk	Youth	Private foundations, NIH	Yes$_2$
Main, 1994	Get Real about AIDS	Youth	CDC	Yes$_2$
Rotheram-Borus, 1997	Street Smart	Youth	NIMH	In Progress$_1$
Stanton, 1996	Focus on Kids	Youth	NIMH	Yes$_2$
St. Lawrence, 1995	Becoming a Responsible Teen (BART)	Youth	NIMH	Yes$_2$

In 1996 CDC's Division of HIV/AIDS Prevention - Intervention Research and Support initiated Replicating Effective Programs (REP) to support the development and dissemination of materials for interventions with evidence of effectiveness. To be eligible, interventions must have met PRS and *Compendium* criteria (see Appendix A). In the first years, REP support was given to the developers of completed studies that met the specified criteria, regardless of source of the original research funding. In future years, when CDC funded studies show positive behavioral/health results, CDC will routinely commit additional funds to development and dissemination. We encourage other funding agencies to do the same.

Section 3
Intervention Checklist

Intervention Checklist:

Elements of Successful Programs
A Tool for Assessment of Local HIV/AIDS Interventions

Background

The *Compendium* provides ready access to many interventions with known effectiveness, however, program planners, managers, prevention service providers, or constituents may be using an existing intervention that has its own advantages. For instance, it was developed locally and there is consensus in the community about its value. The *Intervention Checklist* was developed as a tool to help with assessment of these existing interventions. *Checklist* items were derived from the common characteristics of successful programs.[1] One may want to use the *Checklist* to fine-tune a strong program. Or, one may use it to consider new ideas for program implementation and/or organizational planning. It may be helpful simply as a programmatic inventory.

How to Use This Tool

This *Checklist* may be completed by one person or by a group of people familiar with the intervention activity (i.e., staff, constituents, volunteers, advisory board members). This tool could be used in a regular staff or planning group meeting or an annual program review to help measure progress.

Instructions:

1. Consider each of the four sections and each item within the sections. It may be useful to record examples from your local intervention onto the form in the space provided (if needed, use bottom, back of page, etc.) Also, you may want to add items.

2. Working individually or in a group, complete the *Checklist.* Rate each item High, Medium, or Low. For instance, for the first Intervention item, a clearly defined audience, a "high? rating would mean that the audience is very clearly defined., i.e., with enough precision (e.g., ethnically/culturally; by risk behavior, gender, or other characteristics) for optimal planning, tailoring of materials to that audience, and targeted recruitment.

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[1] **References**

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Kirby, D. (1995). A review of educational programs designed to reduce sexual risk-taking behaviors among school-aged youth in the United States. In *The Effectiveness of AIDS Prevention Efforts, HIV Prevention: State-of-the-Science* , commissioned by the Office of Technology Assessment, compiled and produced by the American Psychological Association Office on AIDS, Washington, D.C.

3. Review your responses. Consider each section separately. For example, are there one or two items in the Implementation section that need attention?

4. How do you/your group assess the current intervention overall? Is it satisfactory or can it be strengthened? If you want to improve the activity, who would develop an action plan for that? What accomplishment would address your current concerns? How feasible is that? What technical assistance might be helpful? What time lines would you anticipate? What resources would be needed?

A. Intervention Items	Examples from Effective Interventions	Examples from Local Interventions (Write In)	Rating (Circle One)
1. The intervention has a clearly defined audience	STD patients who are at risk based on current STD Runaway youth living in shelters who are at risk through survival sex		High Medium Low
2. The intervention has clearly defined goals and objectives	To change [illegible] To increase [illegible] To reduce risk for HIV/STD and unintended pregnancy among youth [illegible]		High Medium Low
3. The intervention is based on sound behavioral and social science theory	Diffusion theory guides plan for key opinion leaders to speak with certain number of people (representing proportion of the at risk population) Stages of change model calls for tailoring the role model stories used in the intervention to level of readiness for risk reduction in the community		High Medium Low
4. The intervention is focused on [illegible]	[illegible]		High Medium Low
5. The intervention provides opportunities to practice relevant skills	Role play condom negotiation with steady sex partner Exercises for trying out personal coping strategies		High Medium Low

B. Implementation Items	Examples from Effective Interventions	Examples from Local Interventions (Write In)	Rating (Circle One)
1. There is a realistic schedule for implementation	Six months of preparation and coordination is needed before starting an intervention in a large health care organization Two years of implementation are required for community level change		High Medium Low
2. Staff are adequately trained for sensitivity to the target population	Staff receive training on responding to disclosures of domestic violence Staff attend [illegible] about the target population's [illegible], risk factors, and barriers to accessing services		High Medium Low
3. Staff are adequately trained to deliver the core elements of the intervention	Peer volunteers receive 32 hours of interactive training on the intervention's goals, objectives, core elements, and delivery methods Staff read intervention manuals, view training videos, role play intervention delivery, and have "booster" training one month after starting the intervention		High Medium Low
4. Core elements of the intervention are clearly defined and understood in the delivery	Health educators use an intervention manual that details the core elements Supervisors observe intervention [illegible] at least once a month and provide feedback on delivery of the core elements		High Medium Low
5. Staff uses a variety of teaching methods, strategies, and modalities to convey information, personalize the training, and repeat essential HIV prevention messages	Lecture, discussion, group art and music projects, stress coping exercises, and individual counseling Staff use of culturally specific video soap opera as a springboard for problem solving client's barriers to condom negotiation; condom information is repeated in large- scale poster format		High Medium Low

C. Organization Items	Examples from Effective Interventions	Examples from Local Interventions (Write In)	Rating (Circle One)
1. There is administrative support for the intervention at the highest levels	State health department commits to delivering the intervention in all STD, HIV, and family planning clinics holding state contracts Local public housing authority provides on site office space for intervention activities		High Medium Low
2. There are sufficient resources for the current implementation	[illegible] intervention [illegible] delivery with its intervention [illegible] [illegible]		High Medium Low
3. There are sufficient resources for sustainability	Redefinition of duties makes intervention delivery part of staff job description Intervention is not tied to grant funding but is part of agency's overall budget		High Medium Low
4. Decision-makers are flexible and [illegible] program changes	"Ownership" of project is shared with [illegible] delivery [illegible]		High Medium Low
5. HIV/AIDS intervention is embedded in a broader context that is relevant to the target population	Runaway youth receive shelter, medical care, mental health counseling, and service referrals in addition to HIV prevention intervention Inner city women receive HIV/AIDS intervention woven into the context of women's health, pregnancy planning, and caring for one's family		High Medium Low

D. Consumer/ Participant Items	Examples from Effective Interventions	Examples from Local Interventions (Write In)	Rating (Circle One)
1. The intervention meets specified priorities and needs defined by the community	Intervention sponsors social events for young men who have sex with men in communities that do not have places for them to congregate Intervention empowers peer volunteers to intervene in their own communities		High Medium Low
2. For the target population selected, the intervention is culturally competent	"Role model" stories used within the intervention(s) are experiences of actual members of the community (with their names changed) English/Spanish video portrays real-life situations, decision-making processes, and condom negotiation strategies in appropriate Hispanic socio-cultural context		High Medium Low
3. For the target population selected, the intervention is developmentally appropriate	The need for safer sex is introduced naturally into the casual conversations of mature adult men who have sex with men Runaway youth, ages 11 to 17, receive intervention messages in many entertaining ways and learn realistic expectations for skills development		High Medium Low
4. For the target population selected, the intervention is gender-specific	An intervention targeting inner-city women is delivered by community women and focuses on women's health issues Young gay men receive an intervention through their social networks		High Medium Low
5. The intervention as implemented is acceptable to the participants	Participants continue to come, even without incentives Participants recommend the intervention to their friends		High Medium Low

Section 4
Appendices

Appendix A

Prevention Research Synthesis (PRS) Project and Selection Criteria

In 1996, CDC began the HIV/AIDS Prevention Research Synthesis (PRS) project to create a database of all HIV/AIDS behavioral, social, and policy studies. The PRS project has several aims:

(1) to permit systematic reviews that address the population, intervention, study design, setting, and outcome factors associated with intervention effectiveness;

(2) to identify methodologically rigorous studies that have significant positive results; and

(3) to identify gaps in the existing research and directions for future study.

The PRS database will be updated annually. At present, it contains approximately 5,000 articles and reports on HIV prevention. Of these, about 200 are intervention studies that meet relevance criteria such as having behavioral or biological outcomes. Further, using criteria for methodological rigor, we identified a subset of *126 primary studies* representing the best available intervention science within the scope conditions of the PRS project. Figure A.1 illustrates the application of these criteria.

A. PRS Criteria

1. **Relevance criteria** -- allow the selection of studies that aim to reduce sex- and/or drug-related risk behaviors. Criteria include:

   (a) Studies are reported from 1988 onward

   The study typically was conducted two or three years earlier. This coincides approximately with the start-up of HIV intervention research.

   (b) Published or unpublished

   Unpublished reports are included in the PRS database to minimize the possibility of "publication bias." (For purposes of the *Compendium*, unpublished reports are included in the database to provide access to the latest studies.)

   (c) Conducted anywhere in the world

   Research conducted both in and outside the United States enhances our understanding of risk reduction.

   (d) Had positive, negative and/or no change (null) findings

   The PRS database includes all studies that meet specific standards of scientific rigor, regardless of outcome. Negative and no-change (null) outcomes contribute to our knowledge of what does and does not work.

   (e) With one or more of the following outcomes:

Sex-related behaviors

- use of male condoms
- use of female condoms
- use of condom negotiation
- not having sex, if condom not used
- having unprotected sex
- number of sex partners
- mutually monogamous relationship
- partner selection
- return to abstinence
- initiation of first sexual intercourse
- exchanging sex for money/drugs

HIV testing behavior

- repeat testing
- return for results

Drug-related behaviors

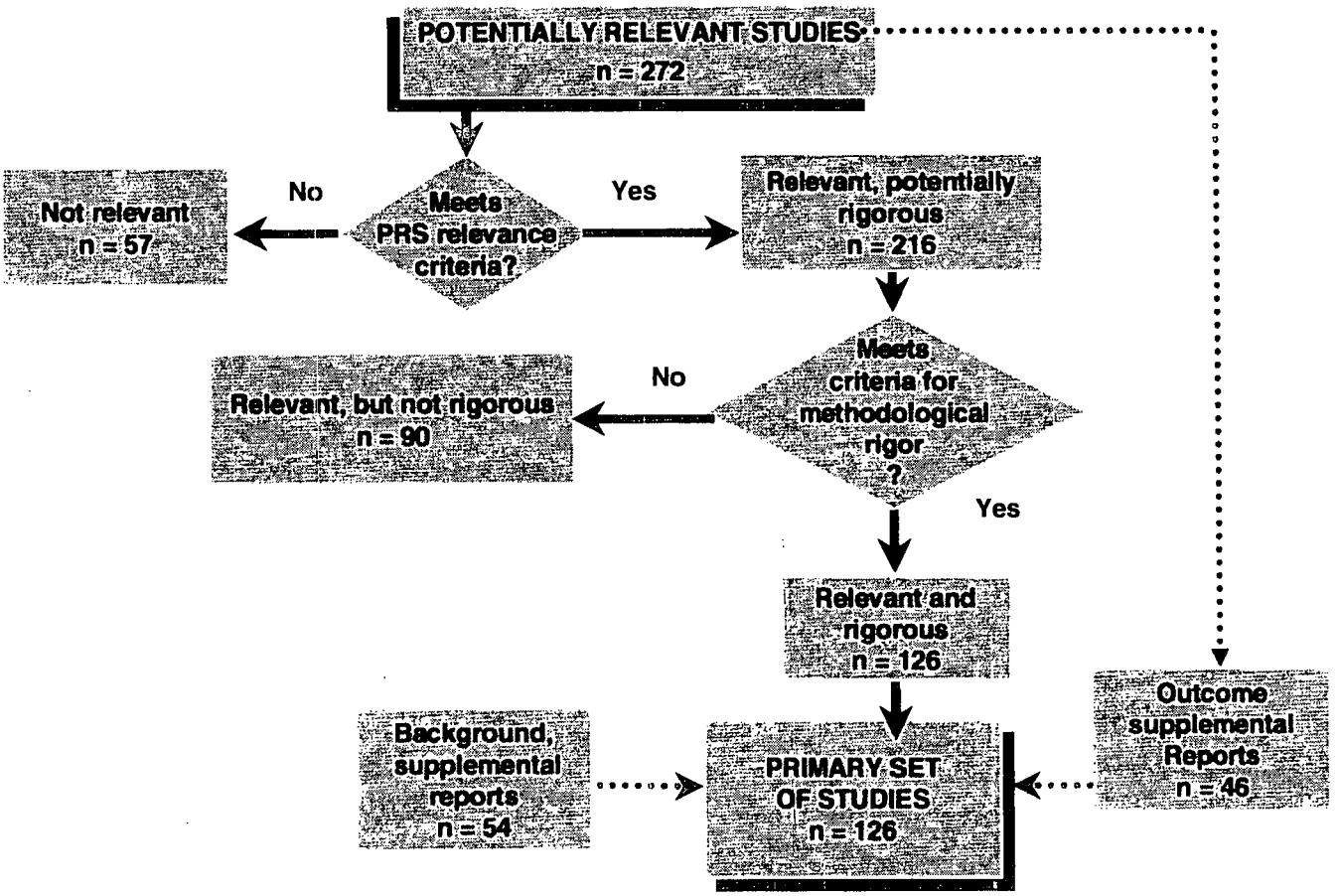
- multi-person use of drug paraphernalia
- cleaning/bleaching drug paraphernalia
- use of new sterile needles/syringes
- injecting drugs
- initiation of drug injection
- non-injecting drug use
- sex with substance use
- return of used syringes

Health outcomes

- incidence rates of HIV, AIDS, STDs, HBV, and HCV
- prevalence rates of HIV, AIDS, STDs, HBV, and HCV

Figure A.1

PRS Review Process: Reviewed *OUTCOME STUDIES*, as of 6/30/98



2. **Methodological criteria** -- based on study design and vary by intervention category[1], i.e., eligible behavioral and social interventions require control/comparison groups and pre-post data whereas policy interventions may have less rigorous designs.

   (a) For *behavioral and social* intervention studies:

   - Random assignment to intervention and comparison groups with
     - pre-post data *OR*
     - post-only data
   - Non-random assignment to groups with
     - pre-post data *AND*
     - adjustment for apparent assignment bias

   (b) For *policy* studies:

   - Random assignment to intervention and comparison groups with
     - pre-post data *OR*
     - post-only data
   - Non-random assignment to groups with
     - pre-post data *AND*
     - no apparent assignment bias *OR*
     - adjustment for apparent assignment bias
   - Non-random assignment to intervention and comparison groups with
     - post-only data *AND*
     - no apparent assignment bias *OR*
     - adjustment for apparent assignment bias
   - Pre-post data with no comparison group

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[1]There are three broad categories of interventions:.

Interventions in the *behavioral* category aim to change individuals' behaviors. These tend to emphasize individual and small group approaches, e.g., counseling, small group discussion with skills demonstration.

Interventions in the *social* category aim to change social norms that influence individuals' behaviors. These interventions may use small group or community-level approaches, e.g., engaging key opinion leaders as educators, community mobilization.

Policy studies aim to change individuals' behaviors and/or norms through administrative or legal decisions, e.g., condom availability in public settings, HIV education in schools.

B. Compendium Criteria

- To identify interventions for this *Compendium* we reviewed the *primary studies* using additional selection criteria:

  1. Studies conducted in the United States
  2. Studies with reported positive results on relevant outcomes
  3. Behavioral and social interventions, excluding policy studies

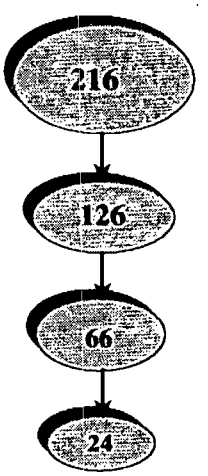
- We then examined this subset, further selecting studies that met the following criteria:

  4. Studies where the positive results represented a statistically significant difference between the intervention and the control or comparison condition
  5. Studies with no negative findings
  6. Studies that are state-of-the-science.

  Figure A.2 illustrates the application of these criteria. Applying all six of these criteria resulted in the 24 interventions contained in this *Compendium.* Within the constraints indicated by the criteria listed above, these represent the best state-of-the-science interventions available as of June 30, 1998.

  Consistent with these pre-established criteria, many studies were *not* selected for the *Compendium.* We did not select, for instance, studies where there was no control or comparison condition in the study design. Many of these studies with other designs provide valuable information but are out of the scope of this *Compendium.* Also, another CDC project, Characteristics of Reputationally Strong Programs[2] (described elsewhere) examines such programs.

Figure A.2 Identify Effective Interventions



Locate prevention studies with behavioral or health outcomes

Select those that meet study design/rigor criteria

Select those conducted in U.S. (Of 84, 74 reviewed)

Identify studies that reported at least one significant positive result

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[2] "Organizational Characteristics of Reputationally Strong Programs," Jane Mezoff, Brenda Seals, Ellen Sogolow, Bob Kohmescher, Gretchen Wooden, Larry Bye, Brian Tjugum, presented at the 12th World AIDS Conference, Geneva, June 28-July 3, 1998.

Appendix B

Source Citations and Supplemental References

This appendix lists the source citations for the 24 intervention studies described in this document. Additional or supplemental references are indented underneath the source citation for each intervention study. These additional references may be background citations (e.g., ones that contain descriptive information about the intervention) or outcome citations (e.g., ones that contain data from a subsequent follow-up assessment). These citations can help program planners obtain further information about the study design, methods, and other findings associated with the studies described in this document.

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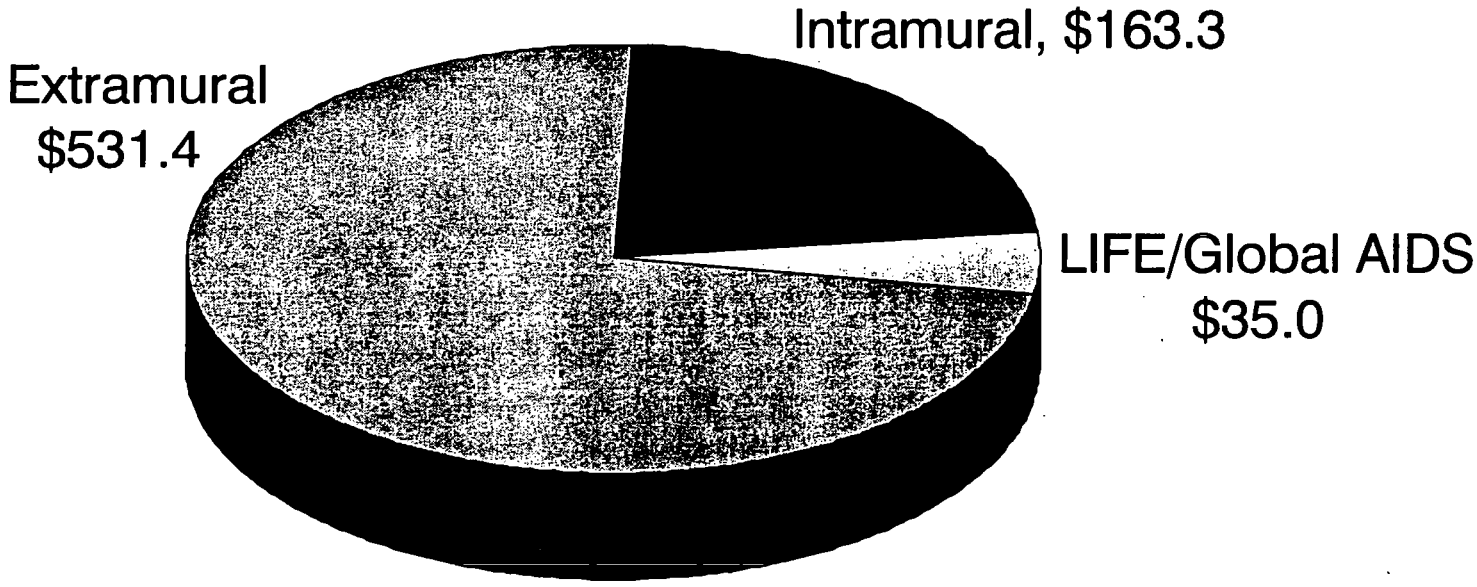
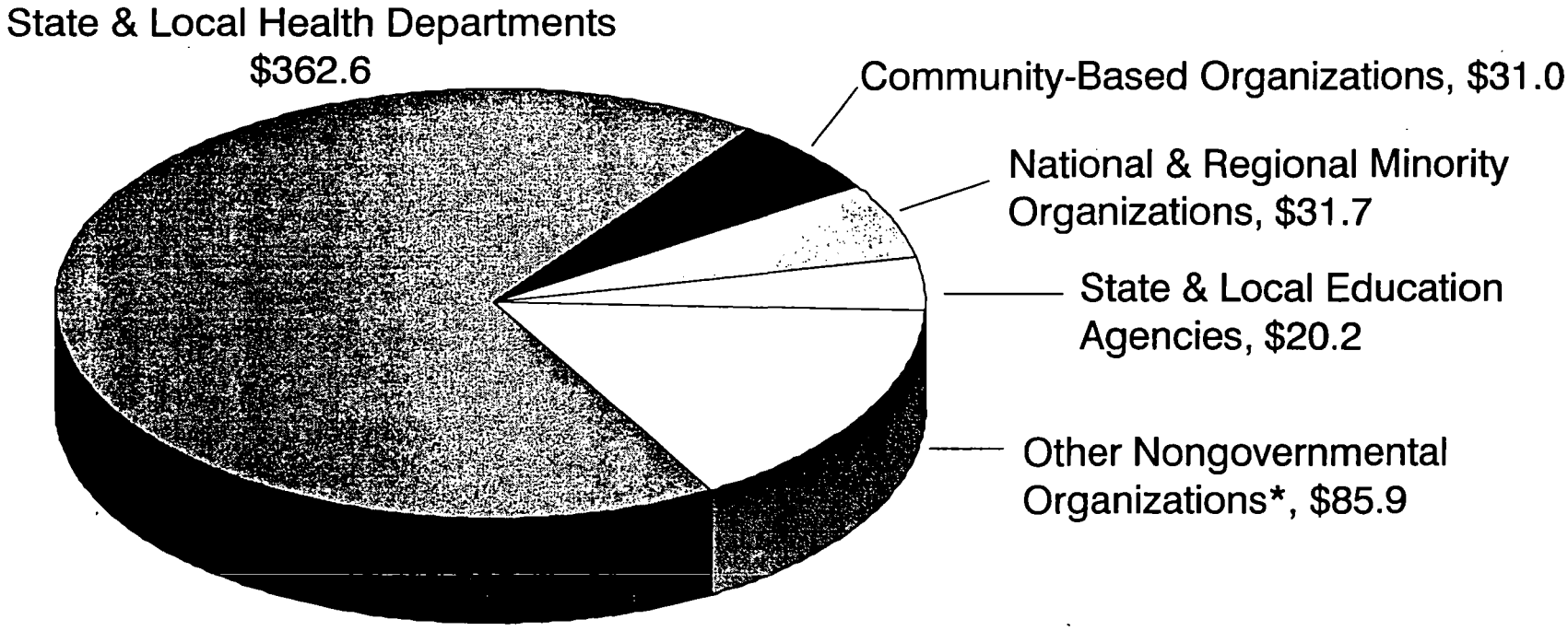
CDC HIV/AIDS Budget (in millions)
Extramural and Intramural
FY 2000 (estimated)



Total: $729.7 million

CDC HIV/AIDS Extramural Budget (in millions)(estimated)
Breakdown by Recipient Organization
FY 2000



Total: $531.4 million

*Universities, hospitals, businesses, non-profit organizations

CDC HIV/AIDS Budget Request (estimated) FY 2001

Increase of $66 million in new funds, $10 million in redirected HIV funds

- **$40 million to expand local prevention efforts**
- **$10 million to increase knowledge of sero-status, link infected into care, and help both infected and uninfected to adopt safe behaviors**
- **$26 million for global AIDS activities**

Total Request: $795.0 million

CDC NCHSTP

CBC-Related Funding Received in FY 1999

- CDC New Appropriations - $18 million
- Public Heath and Social Services Emergency Fund/Secretary's Emergency Fund - $21 million

New CBC-Related Projects

- Community-Based HIV Prevention Projects for African Americans
- Capacity-Building Technical Assistance to Community-Based Organizations
- Community Development Projects for HIV/STD/TB/Substance Abuse Integration and Linkages
- HIV Prevention Projects for African-American Faith-Based Organizations
- HIV Prevention Among Gay Men of Color
- HIV/AIDS Intervention, Prevention and Continuity of Care for Incarcerated Individuals within Correctional Settings and the Community
- Prevention Education and Early Identification Project

CDC NCHSTP

Table 2a

FY 1999 CDC HIV/AIDS Budget[1] by Mission Category[2]

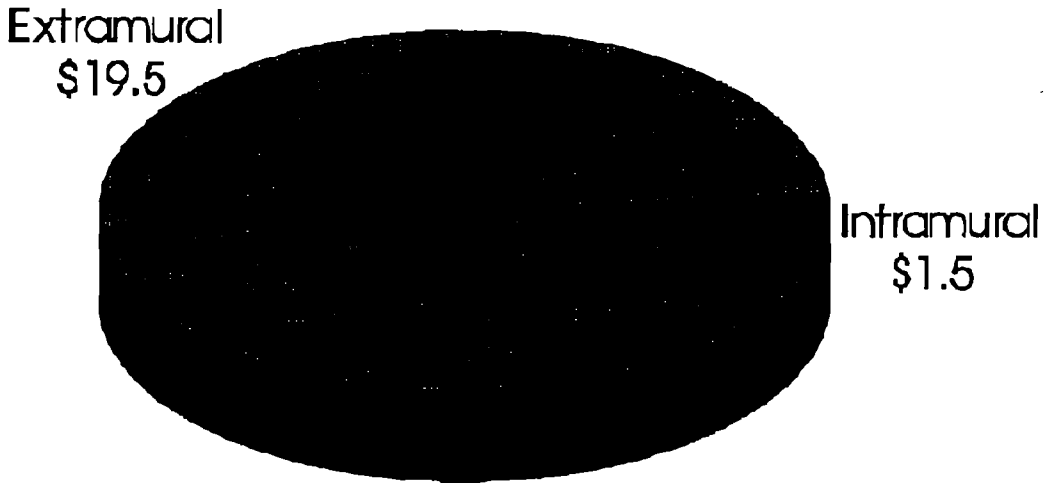
Mission Category	FTEs	Budget	Percentage
Surveillance	194	69,974,610	11 %
Research	356	88,390,089	14 %
Technical Assistance	54	51,967,230	8 %
Intervention/Program Implementation	432	411,895,079	65 %
Program Evaluation	38	12,813,964	2 %
Policy Development	5	1,564,228	<1 %
Totals	**1,079**	**$637,605,200[3]**	**100 %**

[1] Total reflects estimated CIO funding by mission categories and does not necessarily reflect previous FY 1998 HIV/AIDS budget tables. HIV FTEs are determined by HIV/AIDS personnel costs.

[2] Projects often reflect multiple mission categories but for the purpose of this data collection, projects were considered mutually exclusive and the most prominent feature determined mission category.

[3] Centralized Mandatories and 1% Evaluation not included in this total.

Public Health and Social Services Emergency Fund
Secretary's Emergency Fund - FY 1999
(in millions)



Total: $21 million

CDC National Prevention Information Network

A Service of the National Center for HIV, STD, and TB Prevention

Operators of the CDC National AIDS Clearinghouse

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Subject: *CDC Update*

Pages: 5 (INCLUDING COVER)

Organization: WHITEHOUSE OFF OF NATL AIDS POLICY

Phone Number: 202 4562437

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DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta, GA 30333

February 1, 2000

Dear Colleague:

The following is an overview of two important studies that Centers for Disease Control and Prevention (CDC) researchers will present this week at the 7th Conference on Retroviruses and Opportunistic Infections in San Francisco, California.

One study, "Primary HIV Infections Associated with Oral Transmission," was designed to quantify new HIV infections that may have been transmitted by oral sex within a group of 102 men recently infected with HIV. This study found that 7.8% of the men were infected through oral sex. Most of the men stated that they believed oral sex represented either no or minimal risk. While oral sex carries a much lower risk of transmitting HIV than other forms of sex, this study demonstrates that repeated exposures may pose a significant risk.

The other study, "Are At-Risk Populations Less Concerned about HIV Infection in the HAART Era?," sought to determine whether concern about HIV infection and recent HIV risk behaviors have changed as a result of the advent of the Highly Active Anti-Retroviral Therapy (HAART). The study anonymously interviewed 1,976 HIV-negative or untested individuals at risk for HIV infection and found that 31% were less concerned about becoming infected and 17% were "less safe" about sex or drug use, because of new treatment advances. The findings confirm those of smaller studies and that advances in HIV treatment may lead high-risk individuals to become complacent about HIV prevention.

Attached is a background document with more information about the studies. As always, if you have any questions or comments, please feel free to call the NCHSTP Office of Communications at (404) 639-8890.

Sincerely,

Melissa B Shepherd

Melissa Shepherd
Associate Director for Communications
Director, Office of Communications
National Center for HIV, STD, and TB Prevention

CDC UPDATE

Key Findings from CDC...

7th Conference on Retroviruses and Opportunistic Infections
San Francisco, January 30- February 2, 2000

NOTE: INFORMATION UNDER STRICT EMBARGO UNTIL TIME OF PRESENTATION (SEE BELOW)

- **Oral Sex Contributes Significantly to HIV Transmission**
  At least 7.8% of recently-infected gay men in San Francisco study exposed through oral sex

- **Multi-State Study on Impact of New Treatment on HIV Risk Behavior**
  High Risk Individuals Report Less Concern about HIV Infection and Less Safe Sex or Drug Use

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ORAL SEX CONTRIBUTES SIGNIFICANTLY TO HIV TRANSMISSION

"Primary HIV Infections Associated with Oral Transmission,"
Dr. Beth Dillion and colleagues -- Abstract #473, Poster Presentation
(Embargo: Tuesday, February 1, 2000, 12:00 p.m. PST)

In the most definitive study to date, researchers have found evidence that a significant percentage of new HIV infections in some groups of men who have sex with men are due to oral sex, a mode of transmission too often regarded as posing little or no risk. At the 7th Conference on Retroviruses and Opportunistic Infections, the Centers for Disease Control and Prevention (CDC) reports that among a group of HIV-infected men, 7.8 percent were infected through oral sex.

The study, conducted by CDC's Dr. Beth Dillion, in collaboration with researchers at the University of California, San Francisco's Options Project, assessed risk behavior for 102 gay and bisexual men recently infected with HIV and found that oral sex was the only risk behavior for eight of these men. Most of these men stated that they believed oral sex represented either no or minimal risk.

"For some, oral sex is equated with safe sex. However, for the individuals in this study, and for countless others, this false assumption has led to tragic lifelong consequences," stated Helene D. Gayle, M.D., M.P.H., Director of CDC's National Center for HIV, STD, and TB Prevention.

Public health officials fear that many gay men may be increasing the frequency of oral sex as a replacement for higher-risk behaviors but may assume that oral sex is a risk-free activity. While oral sex may carry a much lower risk of transmitting HIV than other forms of sex, this study suggests that repeated exposures may add up to pose a more significant risk.

The study was designed to help assess how many new infections may have been transmitted by oral sex within a group of recently HIV-infected men. Researchers conducted extensive interviews with the men and their partners about risk behaviors around the time of infection.

In the past, it has been difficult to assess whether people were infected through oral sex because most individuals do not engage exclusively in oral sex and because it has not been possible in the past to pinpoint the time of infection. However, a new testing technology recently developed by CDC, Serologic Testing Algorithm for Recent HIV Seroconversions (STARHS), which can pinpoint recent infections, helped to identify the men to be interviewed in the study. All cases where the route of infection appeared to be oral sex were extensively evaluated. If any other risk behaviors were identified by the infected individual or their partner, oral sex was excluded as the route of transmission. Because of these stringent requirements, 7.8% may be an underestimate of transmission through oral sex in this group.

Abstaining from vaginal, anal and oral sex is the most effective way to prevent the sexual transmission of HIV. Individuals who choose to be sexually active can protect themselves by having sex with only one uninfected partner who has sex only with them, or using a latex condom with all forms of sexual intercourse – anal, vaginal and oral.

MULTI-STATE STUDY ON IMPACT OF NEW TREATMENT ON HIV RISK BEHAVIOR

"Are At-Risk Populations Less Concerned about HIV Infection in the HAART Era?," Dr. Stan Lehman and colleagues -- Abstract #198, Slide Presentation, Yerba Buena Ballroom, Section 7 (Embargo: Sunday, January 30, 2000, 4:30 p.m. PST)

In a study of 1,976 HIV-negative or untested individuals at risk for HIV infection, CDC researcher Stan Lehman and colleagues found that 31% were "less concerned" about becoming infected and 17% were "less safe" about sex or drug use because of new

HIV treatments. The findings come from the HIV testing survey (HITS), a seven-state study which utilized anonymous interviews conducted between July 1998 and February 1999, with 693 gay and bisexual men recruited at gay bars, 600 street-recruited injection drug users, and 683 heterosexuals recruited at sexually transmitted disease clinics. The study sought to determine whether concern about HIV infection and recent HIV risk behaviors have changed as a result of the advent of Highly Active Anti-Retroviral Therapy (HAART).

By risk group, 40% of injection drug users, 30% of heterosexuals, and 25% of gay and bisexual men reported being less concerned about becoming infected because of better treatments. The proportion that reported being less safe about sex or drug use was also high across risk groups, with 25% of injection drug users, 15% of heterosexuals, and 13% of gay and bisexual men reporting increased risk because of new treatments.

These findings confirm those of several smaller studies and indicate that new HIV treatments may lead high risk individuals to become complacent about HIV prevention. Public health officials fear that increased risk behavior could result in increased HIV transmission. HIV prevention programs must work to combat complacency and communicate the uncertainties regarding long-term efficacy, as well as the limitations of new HIV therapies. Many may also not realize the complexity and toxicity of these regimens. HIV remains a serious, lifelong disease – that is much better to prevent than to treat.

# # #

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

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CDC

SANDY-

FRI
6/30

Thanks for the meeting this week --
We're all excited about the potential -
Attached is the press kit for Durban -
and new latino report - Newsletter -
Thought you might find interesting -
Have a safe trip - Melissa

http://www.cdc.gov

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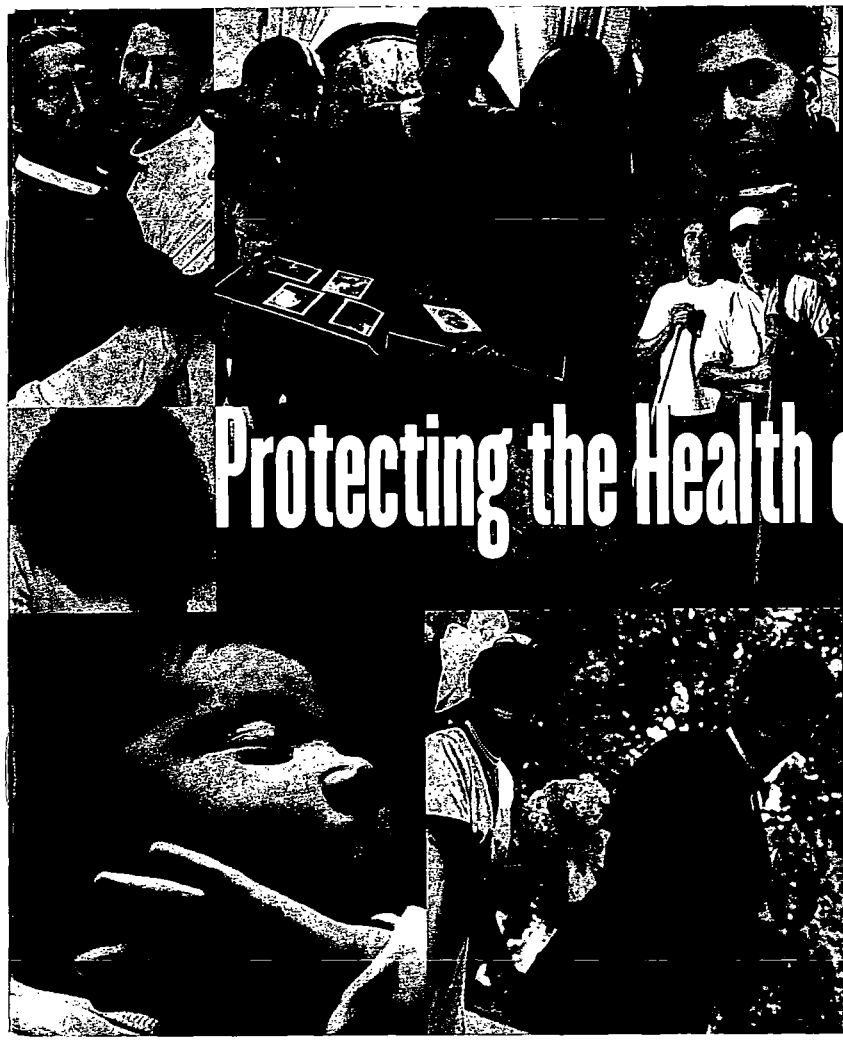

Protecting the Health of Latino Communities

Centers for Disease Control and Prevention
National Center for HIV, STD and TB Prevention
July, 2000

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the Prevention connection

A Newsletter from CDC's National Center for HIV, STD, and TB Prevention SPRING 2000

In this issue:

letter from HELENE GAYLE

WELCOME TO THE PREVENTION Connection, a newsletter from CDC's National Center for HIV, STD, and TB Prevention. We hope you find it to be a useful source of information on CDC-sponsored resources and programs as well as for prevention updates.

We've called the newsletter *The Prevention Connection* for two reasons. One is the interconnectedness of HIV/AIDS, STDs and TB, which has grown increasingly apparent as biomedical and behavioral scientists learn more about people's susceptibility and risk.

Equally important are the interconnections we have with the wider prevention community. Our mission is to support prevention efforts by working in true partnership with others whose goals we share, whether providing surveillance, conducting prevention research, or directly helping communities through funding, training, and technical assistance.

Together we have had some notable successes over the past decade. We have seen the rate of HIV infection hold steady for many years, we now stand on the brink of being able to eliminate syphilis in the U.S., and we are re-energizing our fight against TB, domestically and internationally. Many challenges remain, and it is clear that just as success has been a result of the collective work of many, our ability to transcend evolving problems also depends on ever more collaborative and diverse efforts.

This issue explores some of those challenges - such as the increasingly complex nature of the HIV/AIDS epidemic - and describes some of the programs that are being planned and implemented in response. As we continue to strengthen our efforts domestically, we are ever mindful of the fact that infectious diseases know no boundaries. Therefore, it is equally imperative that we fight these diseases on a global scale. As we join 16,000 of our partners participating in the World AIDS conference in Durban, we are discussing the U.S.-supported LIFE Initiative, one of the efforts featured in this newsletter. In addition to this global initiative, we also highlight in this issue the recent efforts of the Stop TB Initiative and World TB Day this past March.

Finally, we would like to encourage feedback on this issue's contents and comments about how we can make the newsletter even better as a resource for our valued partners in HIV, STD, and TB prevention.

Helene Gayle, M.D., M.P.H., is Director of CDC's National Center for HIV, STD, and TB Prevention.

Send your comments to John Anderton in our Office of Communications at JAnderton@cdc.gov.

LIFE

LEADING THE WAY IN THE FIGHT AGAINST AIDS WORLDWIDE

IN RESPONSE TO THE GROWING GLOBAL AIDS pandemic, the U.S. is providing an additional $100 million in support for sub-Saharan/African countries and India to stem the spread of HIV and provide care for those affected by this devastating disease.

The new program—called the ***LIFE (Leadership and Investment in Fighting the HIV/AIDS Epidemic) Initiative***—is a joint program conducted by the U.S. Agency for International Development (USAID), HHS, and other federal agencies to assist Ministries of Health in Africa and India to mitigate the impact of HIV in their countries.

The investment—double the previous year's increase—will contribute to the broad targets set by UNAIDS: reducing the transmission of HIV by 25 percent and ensuring access to basic care and support services for at least 50 percent of infected persons over the next three years.

The unit within NCHSTP that will implement the LIFE Initiative is the Global AIDS Activity (GAA), which is already hard at work consulting with domestic and international partners to develop broad program guidance and operational plans. To date, the GAA has conducted a series of planning visits which resulted in the development of country-specific program plans.

/LIFE page

SYPHILIS ELIMINATION

HISTORY IN THE MAKING

AT A GATHERING OF PUBLIC HEALTH and political leaders in Nashville on October 7, 1999, U.S. Surgeon General David Satcher and CDC Director Jeffrey Koplan announced a national plan to eliminate syphilis in the U.S. by the year 2005.

The plan capitalizes on the nation's lowest ever recorded rates of the disease, as reported in the October 8, 1999 issue of the *MMWR*. CDC data also revealed a striking regional prevalence pattern, with half of all reported cases concentrated in just 28 counties—less than 1 percent of U.S. counties—mainly in the South and selected urban areas in other regions. The 10 counties with the highest number of syphilis cases reported in 1998 are home to the following cities (in descending order by number of cases reported): Baltimore, Chicago, Memphis, Nashville, Phoenix, Detroit, Indianapolis, Atlanta, Dallas, and Los Angeles.

"The time is now to eliminate syphilis from the U.S.," said Judith Wasserheit, Director of NCHSTP's Division of STD Prevention. "No American should suffer from syphilis. Every stillborn baby, every infant infected, every man and woman infected with HIV because of syphilis should remind us of our obligation to eliminate this disease."

CDC data also indicate that syphilis affects a disproportionate number of African Americans living in poverty. Although the black:white ratio for reported cases has decreased by almost one half since the early 1990s, in 1998 African Americans were still 34 times more likely than whites to be affected. This disparity reflects inadequacies in the health care delivery system. Syphilis is one of the most glaring examples of racial inequalities in health status facing the nation.

The plan targets 33 counties and cities with a heavy burden of syphilis or high potential for re-emergence of the disease. Key strategies include enhanced surveillance, expanded clinical and laboratory services, enhanced health promotion, strengthened community involvement and partnership, and rapid outbreak

/SYPHILIS page

CDC Global AIDS Activity Prospective Procurement Estimates
For FY 2000

The Global AIDS Activity of the National Center for HIV/AIDS, STD and TB Prevention intends to competitively award approximately $20,000,000 in cooperative agreements in Fiscal Year 2000.

What follows is a brief summary of the intended target population of solicitation and a dollar estimation of the award amount.

1. *Community Based HIV/AIDS Prevention and Care Services (Multiple Award)*
   - Anticipated Award Amount: Up to $8,000,000
   - Target Solicitation: Non-Governmental Organizations (NGO's) with demonstrable experience in developing and implementing HIV/AIDS care and prevention and related public health service delivery programs in the context of lesser - developed country environments. The solicitation primarily targets organizations possessing unique experience in working with community- based organizations representing hard to reach and medically underserved populations in both rural areas and large urban centers. The activities will focus on HIV/AIDS prevention via mobilization of communities to advance awareness of HIV/AIDS and its impact in such communities, increasing demand for HIV/AIDS counseling and testing and other prevention services and the development and implementation of community and home-based palliative AIDS care programs.

2. *Partnership and Training between U.S. State HIV/AIDS Programs and LIFE Country National AIDS Control Programs (Sole Source)*
   - Anticipated Award Amount: Up to $1,000,000
   - Target Solicitation: The National Alliance of State and Territorial AIDS Directors (NASTAD). The development of a broad collaboration between NASTAD and individual National AIDS Control Programs (NACP) in LIFE countries. The collaboration would foster peer-to-peer relationships with the intent to transfer the knowledge and skills of State AIDS Program Directors to their national counterparts to assist in the improvement of ongoing HIV/AIDS control program activities, to lend technical assistance in the strategic development of new HIV/AIDS prevention program and policy initiatives, and to provide cognitive and formative training opportunities for NACP staff by facilitating placement of NACP staff within State and Local HIV/AIDS prevention program offices here in the United States, attendance at State HIV/AIDS program sponsored conferences and workshops and other relevant training courses.

3. *Partnership and Technical Assistance between State Public Health Laboratories and LIFE Country National HIV/AIDS Laboratory Programs (Sole Source).*
   - Anticipated Award Amount: Up to $1,000,000
   - Target Solicitation: The Association of Public Health Laboratories (APHL). Via either an increase to the existing PHPPO cooperative agreement or under a new agreement APHL would advance a broad collaboration between State Public Health laboratories and LIFE Country National Public Health laboratories. The collaboration would entail the provision of APHL technical assistance in assessing current national HIV/AIDS, STD and TB reference diagnostic capacity and to strengthen the capacity national laboratories to meet real and planned needs in laboratory testing and quality assurance. The collaboration would also support the development of direct State laboratory to country national laboratory working relationships which would facilitate the provision of on-going technical assistance from APHL and the creation of cognitive and formative training opportunities for LIFE country laboratory staff within the State public health laboratory environments and related and relevant training courses within their own country or region.

4. *Joint United Nations Programme on HIV/AIDS (UNAIDS) (Sole Source):* Up to $5,00000

   - Target Solicitation: To collaborate with the UNAIDS Secretariat, through all U.N. Co-Sponsor Agencies to provide technical assistance in developing the capacity of National AIDS Control Programs in LIFE countries to further the development of National AIDS Control Program (NACP) strategic plans, and to further the technical capacity of NACPs to mobilize resources – both human and capital – to support and implement HIV/AIDS prevention and care programs.

5. *Mobilization of Faith Communities (Sole Source:* Up to $250,000
   - Target Solicitation: The Balm in Gilead. To access the unique experience of Balm in Gilead in mobilizing the African American Faith Community to advance awareness of HIV/AIDS and its impact on the African community. The Balm in Gilead would provide direct technical assistance to African religious leaders representing primarily the Anglican faith communities in Eastern and Southern Africa, as well as other denominations with a significant presence within populations heavily affected by HIV/AIDS. In addition, African religious leaders would have the opportunity to gain direct experience in working with peers within the American Black Church community via participating in Balm sponsored training, workshops and conferences held throughout the United States.

8. *Youth Focused HIV Prevention Activities (Sole Source):* Up to $1,000,000

   - Open Competitive Solicitation: To facilitate the development of partnerships via the provision of technical assistance between U.S. based Youth Service Organizations and National AIDS Control programs in LIFE Countries. The primary focus is to capitalize on Advocate's experience with adolescent reproductive health issues for young people around the globe with specific focus on developing countries.

CDC Global AIDS Activity
FY2000 Expenditure Projections

		Projected Totals By Major Line Item
CDC HQ Held Cooperative Agreements	$	9,500,000
USAID HQ Held Contracts, Grants, Cooperative Agreements	$	5,000,000
CDC Direct Post Program Support	$	15,200,000
CDC HQ Program Support	$	3,200,000
CDC Support Cost	$	2,100,000
Grand Total	$	35,000,000

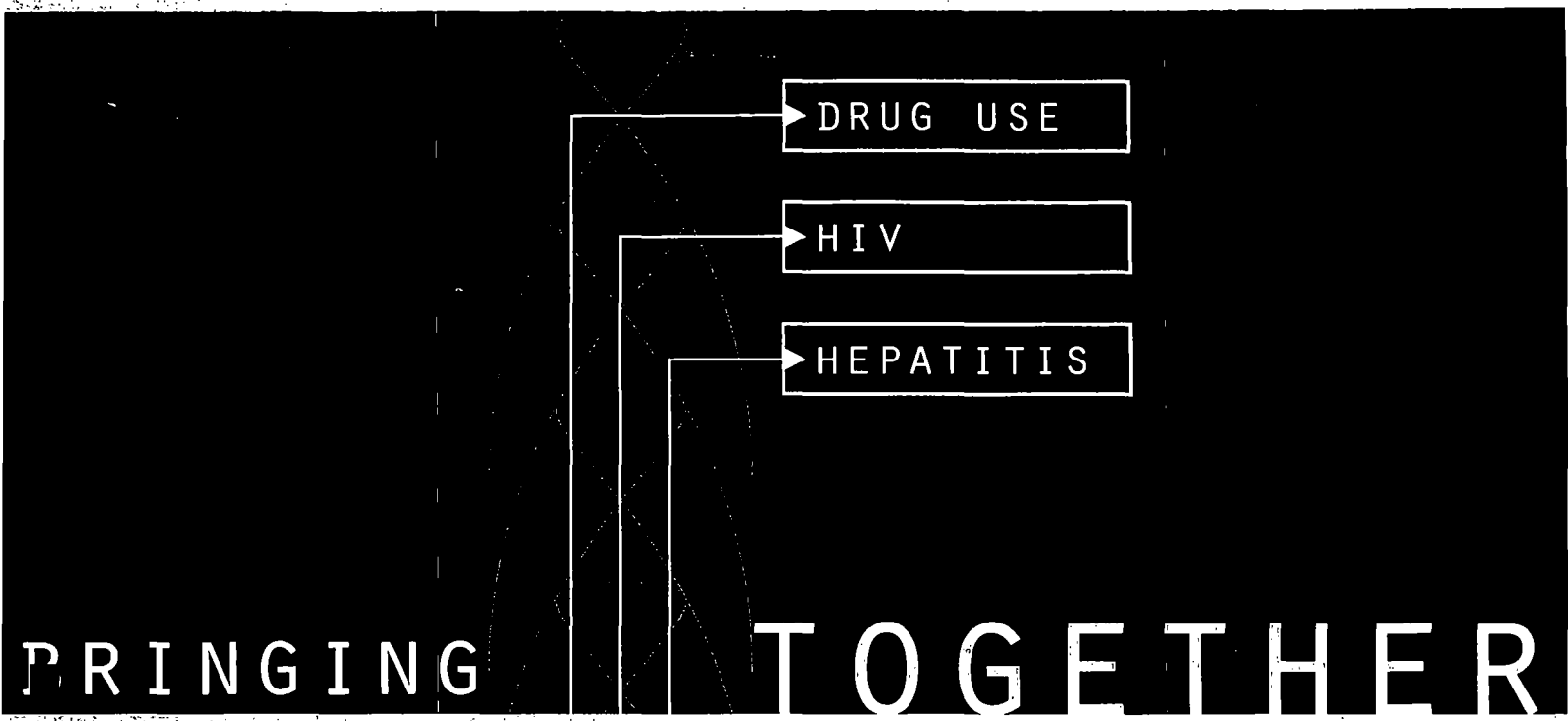
Centers for Disease Control and Prevention
Global AIDS Activity
LIFE Initiative Contribution by Country Specific
Expenditure Projections for FY2000*
25-Aug-00

Country	Projected Expenditure Breakdown by Country	
Botswana	$	4,125,405
Cote d'Ivoire	$	5,178,056
Ethiopia	$	1,353,920
Kenya	$	5,119,544
India	$	488,033
Malawi	$	869,782
Mozambique	$	1,024,240
Nigeria	$	749,346
Rwanda	$	1,028,147
Senegal	$	576,467
South Africa	$	3,985,807
Tanzania	$	1,898,704
Uganda	$	4,781,769
Zambia	$	2,444,321
Zimbabwe	$	1,376,459
Projected Total	$	36,000,000

**Note: All totals shall vary depending on country specific needs and end of year funds availability*

CDC Global AIDS Activity
FY2000 Expenditure Projections

Country	Primary Prevention Total	Home Based Care And Treatment	Capacity and Infrastructure	Total by Country
Botswana	$ 2.5	$ 0.6	$ 1.0	$ 4.1
Cote d'Ivoire	$ 1.9	$ 1.0	$ 2.3	$ 5.2
Ethiopia	$ 0.6	$ 0.3	$ 0.4	$ 1.3
Kenya	$ 2.3	$ 1.0	$ 1.8	$ 5.1
India	$ 0.2	$ 0.1	$ 0.2	$ 0.5
Malawi	$ 0.3	$ 0.1	$ 0.5	$ 0.9
Mozambique	$ 0.3		$ 0.7	$ 1.0
Nigeria	$ 0.1	$ 0.1	$ 0.6	$ 0.8
Rwanda			$ 1.0	$ 1.0
Senegal	$ 0.3	$ 0.05	$ 0.2	$ 0.6
South Africa	$ 1.5	0.4	$ 2.1	$ 4.0
Tanzania	$ 0.3	$ 0.5	$ 1.1	$ 1.9
Uganda	$ 1.2	$ 0.8	$ 2.7	$ 4.8
Zambia	$ 0.8	$ 0.4	$ 1.3	$ 2.5
Zimbabwe	$ 0.3	$ 0.6	$ 0.5	$ 1.4
Total				$ 35.0



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- National Institute on Drug Abuse/National Institutes of Health
- Centers for Disease Control and Prevention

Registration materials available November 1, 1999
For more information and to request registration materials
▶WEBSITE www.chhatt.net ▶EMAIL conference@chhatt.net
▶TOLL FREE 1-877-565-3693 ▶LOCAL 1-301-565-3693 (MD, DC, VA)

The Honorable Sandra Thurman
Director
Whitehouse Off of Natl AIDS Policy
736 Jackson Pl NW
Washington, DC 20503

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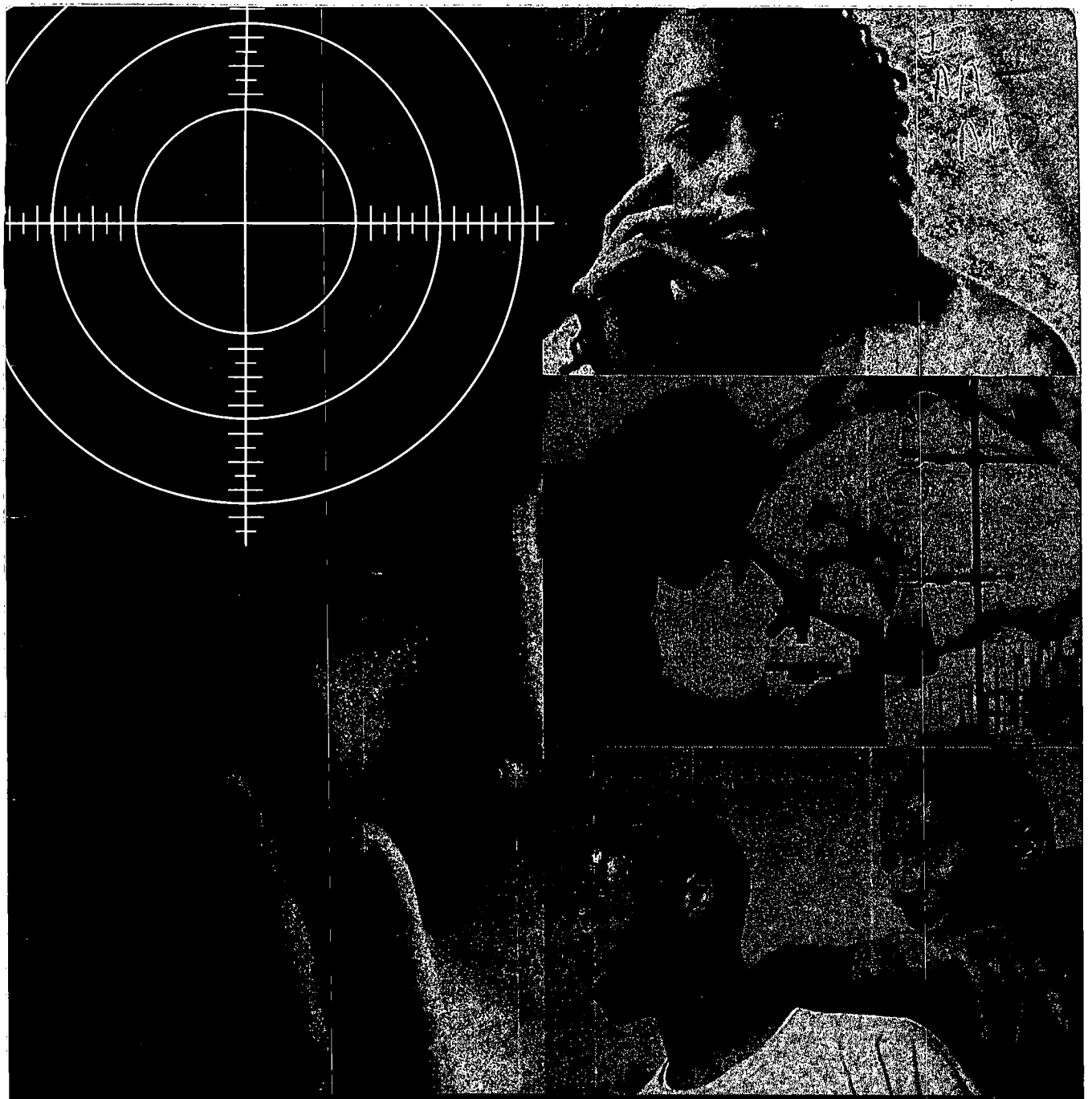

Fighting HIV/AIDS in African-American Communities

Centers for Disease Control and Prevention
National Center for HIV, STD and TB Prevention

AUGUST 1999

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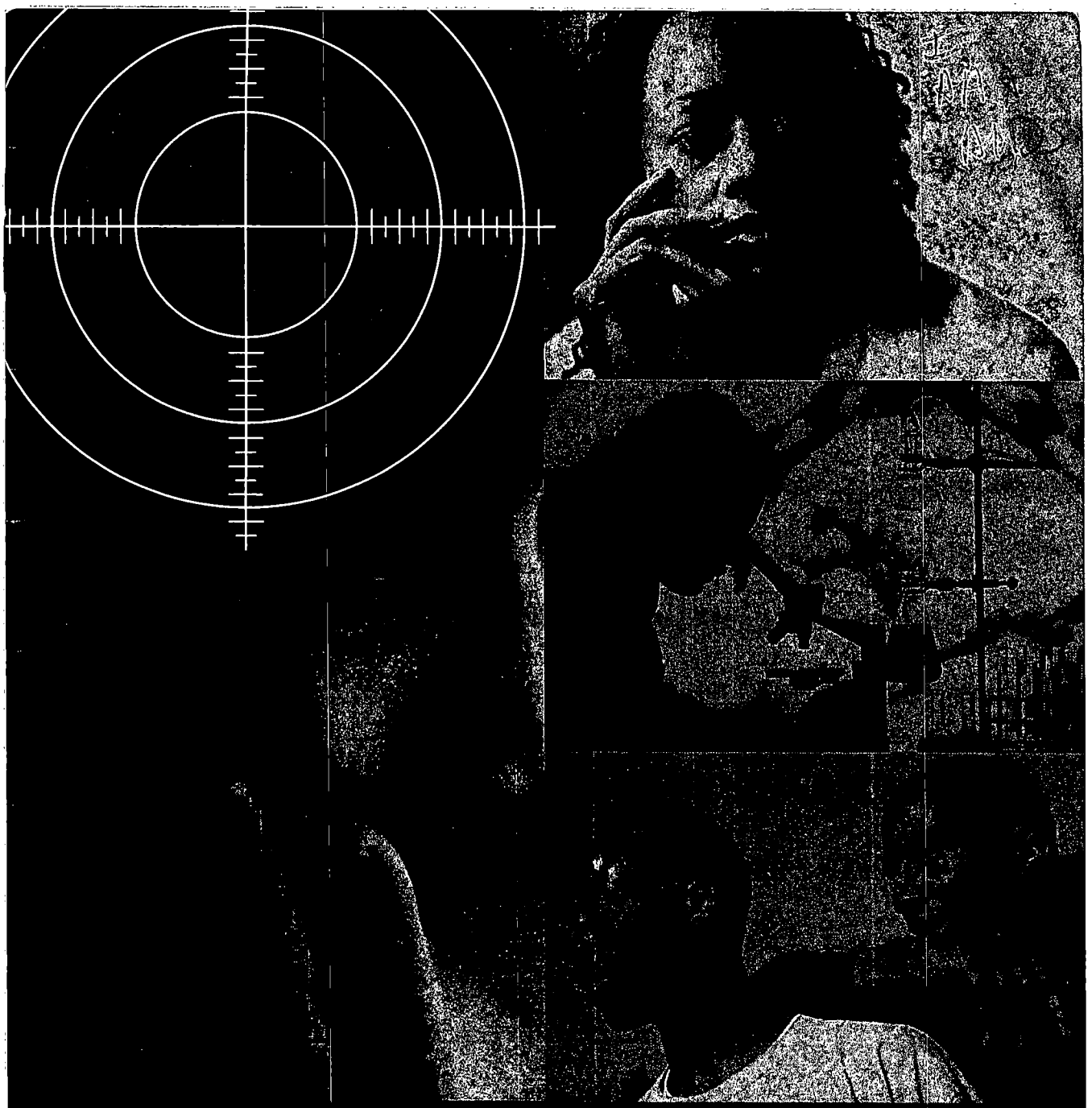

Fighting HIV/AIDS in African-American Communities

Centers for Disease Control and Prevention
National Center for HIV, STD and TB Prevention

AUGUST 1999

0-CDC

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

John Edward Porter
U.S. House of Representatives

Arlen Specter
U.S. Senate

0 - CDC

CDC National Prevention Information Network

A Service of the National Center for HIV, STD, and TB Prevention

Operators of the CDC National AIDS Clearinghouse

P.O. Box 6003

Rockville, Maryland 20849-6003

Phone: (800) 458-5231 TTY: (800) 243-7012 Fax: (888) 282-7681 International: (301) 562-1050

CDC Broadcast Fax Cover Page

Date: September 27, 2000

Pages: 2

To: The Honorable Sandra Thurman

Organization: Off of Natl AIDS Policy

Fax Number: 2024562438

Phone Number: 4562437

Subject: Hotline Integration

MAY CONTAIN TIME SENSITIVE INFORMATION

Please deliver to the intended recipient immediately! This fax may contain time sensitive information.

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta, GA 30333

September 26, 2000

Dear Colleague:

We are happy to announce that the CDC National STD Hotline and National AIDS Hotline have combined staff, resources and information to become the CDC National STD and AIDS Hotline. These hotlines operate toll free 24 hours a day, seven days a week, providing callers with anonymous, confidential, and reliable answers to their questions about sexually transmitted diseases (STDs) and HIV/AIDS. The hotlines also provide referrals and free printed materials to callers with STD and HIV/AIDS-related questions.

Some of the highlights and benefits of this integration include:

- Operators will now be available 24 hours a day, 7 days a week for those needing assistance and information about STDs and HIV/AIDS.
- The ability of a caller to get through to a live operator will be greatly enhanced. Call blockage will be significantly reduced.
- Operators will now be throughly knowledgeable about both STDs and HIV/AIDS.
- The phone numbers for the hotlines remain the same, and are listed below.

Information is the first line of defense in preventing STD and HIV infection. Unfortunately, there is still a great deal of stigma attached to discussions of these issues. The CDC National STD and AIDS Hotlines can help by offering reliable information in a friendly, non-threatening, non-judgmental atmosphere.

The hotline is operated under contract by the American Social Health Association (ASHA), a non-profit organization dedicated solely to the prevention and control of STDs.
For answers to your STD/AIDS related questions, referrals to local test sites, treatment centers, or other services, please call:

CDC National STD & AIDS Hotlines
1-800-342-2437 or 1-800-227-8922
English Service (24 hours a day, 7 days a week)
1-800-344-7432 - Spanish Service (8:00 AM - 2:00 AM, 7 days a week)
1800-243-7889 - TTY Service (10:00 AM - 10:00 PM, Monday - Friday)

For more information about the programs and services of the CDC National STD and AIDS Hotlines, please contact Tracey A. Adams at 919-361-8439 or via e-mail at traada@ashastd.org.

Sincerely,

Helene D. Gayle

Linda L. Alexander

Helene D. Gayle, M.D., M.P.H
Director
National Center for HIV, STD, and TB Prevention

Linda L. Alexander, P.H.D.
President and CEO
American Social Health Association

CDC

CENTERS FOR DISEASE CONTROL AND PREVENTION

National Center for HIV, STD & TB PREVENTION

EMBARGOED FOR RELEASE: WEDNESDAY, SEPTEMBER 27, 11:00 AM

CDC Statement Following the Release of IOM Report

Statement from Helene Gayle, M.D., M.P.H., Director
National Center for HIV, STD, and TB Prevention
Centers for Disease Control and Prevention (CDC)

Our nation's HIV prevention initiatives have helped slow the rate of new HIV infections from more than 150,000 annual infections in the late 1980s to approximately 40,000 annual infections today. The number of infants in the United States who acquire HIV from mother-to-child transmission declined by 75 percent from 1992 to 1998. Yet, at the same time, the HIV epidemic has become increasingly complex and new challenges for HIV prevention have surfaced. The expansion of the HIV/AIDS epidemic to diverse populations, the advent of highly active antiretroviral therapy (HAART), and the emergence of complacency all contributed to the Centers for Disease Control and Prevention's decision last year to undertake a series of steps to reevaluate and refine HIV prevention efforts.

One of the steps CDC took was to commission the Institute of Medicine (IOM) to study HIV prevention in the United States and publish a report to provide a visionary framework for national HIV prevention activities.

The IOM today released the report, *No Time to Lose: Getting More from HIV Prevention*. CDC appreciates the work of IOM and the expert committee they convened to address one of the most complex and critical public health issues facing our nation — the prevention of HIV infection. We welcome the contribution this report can make to an informed public dialogue about HIV prevention and to what we hope will be a renewed national commitment to averting as many HIV infections as possible.

The report makes it clear, first and foremost, that HIV prevention works. CDC applauds that central finding, as it lends further support for the fact that scientifically based prevention is core to winning our nation's battle against HIV and AIDS.

The "visionary framework" of the IOM report includes many important

recommendations. CDC is nearing completion of a new five-year national prevention plan – currently available for public comment -- that addresses many of the issues outlined in the IOM report. CDC's ongoing commitment is to make prevention programs as targeted, relevant, and cost-effective as they can be. We look forward to carefully reviewing the IOM report and engaging our partners at state and local health departments, community-based organizations, and public health, academic and medical institutions in discussions about the detailed recommendations. All of us have an important role to play in once again making HIV prevention a national priority.

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