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**The CDC Advisory Committee
on the Prevention of HIV Infection**

**External Review
of HIV Prevention Strategies**

Final Report

Thirteen years after its recognition, the epidemic of human immunodeficiency virus (HIV) infection continues to pose an enormous threat to American health. Approximately 40,000 to 80,000 new HIV infections still occur yearly among men, women, and children in the United States. Each costs the American people dearly in direct medical costs and far more in lost earnings, social upheaval, and personal suffering. The resulting HIV-related deaths from a year's new U.S. infections are equivalent to the total mortality of the Vietnam War. The stakes in devising and implementing more effective ways to prevent new HIV infections are therefore immense.

The prevention task has also reached immense proportions. Approximately three-quarters of a million Americans are estimated to be HIV infected, with many unaware of their infection status. Their sex or drug-use partners are at very high risk of acquisition of HIV infection and need to be reached with interventions to prevent continued transmission. Millions of others have a short-term risk that is currently lower, but nonetheless real, especially over time. To address this great need, the national HIV prevention program must reach tens of millions. This is a massive effort, requiring insightful and committed leadership, science-based policies and strategies, careful planning, ample resources, strong public and private sector alliances, and a comprehensive system of health services. While much has been accomplished, constraints in each of these areas have hampered prevention efforts since the early years of the epidemic, and much remains to be done.

CDC'S HIV PREVENTION PROGRAM

The lead responsibility for implementing the federal HIV prevention program lies with the Centers for Disease Control and Prevention (CDC). The program has evolved since the mid 1980s to include support for state and local health department programs, a national public information network, and education programs in the nation's schools--as well as epidemiologic, behavioral, health services, and laboratory studies, and disease monitoring. These activities are dispersed among ten centers, institutes, and offices within CDC, administered separately, and coordinated by the Office of the Associate Director for HIV/AIDS. (See Appendix A.)

CDC's strategic planning for HIV prevention began in 1989. Phase I established *four general goals*:

- 1) Assess risks
- 2) Develop prevention technologies
- 3) Build prevention capacities
- 4) Implement prevention programs

Building on this broad strategy, Phase II focused on four groups at increased risk for HIV infection: women and infants, injecting drug users, youth in high-risk situations, and men who have sex with men. In Phase III, CDC outlined *five program strategies* expected to have the

greatest HIV prevention impact. These strategies, and their corresponding programmatic focus within CDC, are as follows:

1. **Strengthen current systems and develop new systems to monitor the HIV/AIDS epidemic, as a basis for directing and assessing HIV prevention programs**

CDC's HIV/AIDS monitoring activities are concentrated in the National Center for Infectious Diseases (NCID). This Center maintains AIDS case surveillance; monitors the prevalence of HIV infection; supports studies of HIV-associated morbidity and mortality; provides technical assistance to standardize HIV infection reporting and evaluate other monitoring efforts; conducts epidemiologic studies to describe the natural history of and risk factors for HIV infection; assesses the nature/frequency of blood exposures, infection risks, and efficacy of preventive measures in health-care settings; and conducts laboratory studies to identify factors involved in HIV virulence, transmission, and disease. The National Center for Health Statistics (NCHS) and National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) also conduct important surveillance activities, especially related to attitudes and risk behaviors.

2. **Increase public understanding of, involvement in, and support for HIV prevention**

These activities are centered in the National AIDS Information and Education Program (NAIEP), located in the Office of the Associate Director for HIV/AIDS. As CDC's national public information program, NAIEP helps ensure access to information about HIV/AIDS and improve community support for behavior change. Since 1987, NAIEP has operated the mass media communication effort "America Responds to AIDS", the CDC National AIDS Hotline, the CDC National AIDS Clearinghouse, initiatives to create partnerships with the private sector, and evaluation research. In addition, the National Center for Prevention Services (NCPS) provides funding to the public information components of the cooperative agreements with State and local health departments.

3. **Implement comprehensive school health education programs to prevent the initiation of risk behaviors that lead to HIV infection and other health problems in youth**

School health activities are administered by CDC's NCCDPHP. Since 1987, NCCDPHP has undertaken initiatives to help schools develop, implement, and evaluate HIV/AIDS education programs. The Center supports the training of teachers, administrators, policymakers, and representatives from youth-serving organizations on effective HIV prevention education methods. A limited number of activities are also directed to youth who are not in school. In addition, the NCPS funds community-based organizations to provide outreach, counseling, testing, and referral programs for out-of-school youth. The NAIEP also targets youth through its public information campaign.

4. Collaborate with prevention partners to prevent or reduce HIV-related risk behaviors

NCPS administers CDC's prevention partnerships with federal agencies, health departments, non-governmental organizations, and community groups involved in HIV-related behavior-change activities. NCPS provides support to these organizations by either direct funding or indirect funding via cooperative agreements with health departments and/or the U.S. Conference of Mayors. Collaboration has evolved to include technical assistance, training, education, behavioral research, and outreach. Target audiences, which have expanded over the years in response to the changing demographics of the epidemic, include persons with hemophilia, men who have sex with men, substance users, out-of-school youth, commercial sex workers, the homeless, persons in correctional facilities, and women in high-risk situations.

5. Increase knowledge of HIV serostatus and improve referral systems to appropriate prevention and treatment services

The main focus of CDC's HIV prevention effort has been the counseling, testing, referral, and partner notification (CTRPN) program, also administered by NCPS. State-based CTRPN activities currently constitute the largest proportion of funding for HIV prevention services by health departments and other organizations. Their stated purpose is to provide persons at risk for HIV infection an opportunity to 1) learn their serostatus, 2) receive prevention counseling, 3) obtain referrals for additional services, and 4) if infected, help their sex and needle-sharing partners receive prevention services and referrals.

EXTERNAL REVIEW OF CDC'S FIVE HIV PREVENTION STRATEGIES

In early 1993, CDC initiated an external review of these five program strategies. Acknowledging that the prevention program was built rapidly in response to recognition of the epidemic in the 1980s. CDC staff believed it appropriate to step back, assess their approach to prevention, and obtain recommendations to enhance future success.

Each of the five program strategies therefore became the subject of an investigation by one of five external review groups. Over an 8-month period, each group reviewed CDC's current activities related to one of the five strategies, consolidated their findings, and developed recommendations. Functioning as subcommittees of the CDC Advisory Committee on the Prevention of HIV Infection (ACPHI), the groups were each composed of approximately ten members, including three representatives from the CDC ACPHI, one of whom served as Chair. The other participants, all subject experts from outside CDC, served as consultants, with a lead consultant acting as Co-Chair.

Each review group developed its own process and produced a comprehensive summary report. The complete reports are included in this document. They provide essential descriptions of each group's review process in addition to detailed findings and recommendations.

Representatives of the five groups formally presented these reports to the CDC ACPHI on November 17-18, 1993.

GENERAL FINDINGS

The full Advisory Committee's review and discussion of the subcommittees' reports yielded nine common themes that the members viewed as important to highlight:

1. Prevention is necessary and urgent.

HIV infection is an urgent, and unique, prevention challenge because of the virus' virulence, long incubation period, length of infectiousness, grave prognosis, and potential for exponential spread. The epidemic is fostered by a complex interaction of biological, behavioral, and social forces. It is a growing problem in disenfranchised communities that are faced with a multitude of other compelling problems. And it emanates from the most personal and private of individual behaviors--sex and drug use. With neither a cure nor a vaccine on the immediate horizon--and with a huge national reservoir of infection--the only promising barrier against the virus is widespread adoption and maintenance of personal behaviors that eliminate or minimize the chances of exposure and infection.

Preventing new HIV infections requires a commitment from all levels of government to the diverse neighborhoods of America. The lack of such a commitment, along with restrictive federal policies, has weakened the prevention effort since the onset of the epidemic--constraining funding, limiting flexibility, discouraging innovation, and thwarting prevention specialists in their efforts to use resources where they would be most effective. Added to this set of problems is the relegation of prevention to a status secondary to that of treatment. Although progress in treatment of those already HIV infected must and will continue, it is not a substitute for prevention. With the prospect of ever-more-complex and expensive treatment regimens, prevention will continue to get short shrift unless the nation's leadership maintains a clear financial and moral commitment to prevention as the fundamental weapon against continued of the epidemic.

2. Behavior can be changed.

Both formal research and the practical experience of communities demonstrate that intensive interventions *can* reduce risk behaviors. Relatively little is known, however, about the comparative effectiveness of different approaches to induce desired changes. Despite advances in knowledge in recent years, we are only beginning to understand how to help people make the leap from possessing information about health to changing their behavior on the basis of that information. Nonetheless, given the enormous social and economic costs of the HIV epidemic if permitted to run its present course, even modest behavior changes must be viewed as successful. The essential question--still unanswered--is what *set* of interventions can change *most* people's behavior *most* of the time--*over a lifetime*.

3. Prevention should be guided by science.

Since behavior change is the main prevention intervention for HIV infection, behavioral research must be the foundation upon which the national program is based.

Unfortunately, the nation has invested inadequately in prevention research, especially as it concerns human sexuality and drug-use behaviors. Thus, much essential knowledge still eludes us. The key role for CDC is to develop, synthesize, and promulgate scientific guidance for the HIV prevention activities carried out by community organizations and state and local health authorities. This means clarifying goals, definitions, and measures of effectiveness; identifying successful and unsuccessful strategies; and developing and applying quality standards. The task will require considerable strengthening of the science base as well as substantial increases in funding for prevention research.

4. Prevention requires sustained, long-term efforts.

Despite hopes to the contrary, the HIV/AIDS epidemic is not a transitory crisis with a "quick fix." Pressures to come up with fast, easy solutions have left us with a prevention model that is inadequate to address the *lifetime risk* of HIV infection: We must both initiate *and sustain* changes in risk behaviors; we need *generational changes in social norms*. The urgency of the escalating epidemic calls for an acceleration of both the scale and the scope of the national prevention agenda. CDC must move away from the short-term infectious disease control model and instead mount a long-term effort similar to those instituted for smoking cessation and prevention of heart disease. This does not mean that the sense of urgency should be lost; on the contrary, short-term "emergency" efforts are still needed, with scientific lessons summarized and applied as soon as possible. But, just as some research involving treatment of breast cancer or diabetes takes many years to yield valid results, so, too, must HIV prevention efforts have long-term support.

5. Partnerships and collaboration are key.

Problems with programmatic cohesion both within the federal government and with others involved in HIV prevention at the national, state, and local levels has severely hampered the prevention effort. Several federal agencies in addition to CDC, as well as health departments, non-governmental organizations, corporations, religious organizations, and academic institutions all have parts to play in funding, planning, and implementing prevention activities. Although CDC has the lead in these efforts, opportunities have clearly been missed for establishing and promulgating a unified agenda for prevention services and research. CDC, or some other federal entity, must take responsibility for developing functional alliances, promoting participatory planning, encouraging communication, and ensuring coordination.

CDC's recent initiation of a community planning process for the awarding of HIV prevention grants is a welcome response to some of these problems. But the process will need to be monitored closely to ensure that communities have sufficient time and

technical assistance to meet their new responsibilities. There is also the danger that "bottom-up" community planning will lead to abdication of CDC's responsibility to provide needed oversight and scientific guidance. A local organization's deep commitment to HIV prevention and strong community ties does not guarantee it the requisite knowledge and skills to design and successfully carry out a broad, long-term prevention program. The line between support and responsible supervision on the one hand, and arbitrary interference on the other, presents a major challenge for the CDC.

6. Prevention interventions must strike a balance between targeted efforts and efforts to change general community norms.

HIV prevention is complicated by a problematic epidemiologic reality: nearly all Americans are at some risk of HIV infection, but their *degree* of risk varies dramatically. Those charged with carrying out prevention must choose strategies and allocate resources with this uneven risk in mind. There can be no standard formula; we must constantly question whether the right balance is being achieved. Insufficient attention to the highest-risk populations will squander resources and fail to halt the epidemic's spread. Limitation of outreach to *only* those at highest risk will promote a false sense of security, miss some opportunities to prevent HIV infection, and limit public support for national prevention efforts.

7. More funding for prevention is needed.

Excessively limited resources and inappropriate restrictions on their use have hampered HIV prevention efforts. Although CDC's total HIV prevention budget has grown from \$200,000 in fiscal year 1981 to \$498.2 million in fiscal year 1993, funding for the prevention program was essentially flat over the last 3 years (with an actual decrease in fiscal year 1992). Despite an increase to \$543 million in 1994, the level of federal financial commitment to HIV prevention is inadequate to address the overwhelming need for *long-term, sustained, individual-level behavior change interventions for millions* of at-risk and HIV-infected persons. Restrictive policies and Congressional earmarks attached to these funds have further curbed flexibility and prevented the implementation of innovative and important prevention approaches. The Committee recognizes that although HIV prevention is expensive, the alternative--unchecked spread of infection continuing indefinitely--is many times more costly.

8. Stigmatization and discrimination continue to adversely affect prevention efforts.

Despite progress in the development of a caring and compassionate national attitude toward persons with HIV infection and AIDS, ignorance, bigotry, and discrimination still pose obstacles to prevention. A continuing effort to dispel misconceptions about HIV transmission and to protect the confidentiality and human rights of those with or at risk for HIV infection must be an integral part of the national prevention agenda.

9. CDC's organizational structure may be hindering prevention efforts.

CDC's HIV prevention programs are dispersed among ten centers that compete internally for resources; the effort lacks a clear line of authority for policy, programming, and budget from HIV leadership to staff. CDC's main HIV prevention activities are subsumed within the Division of STD/HIV Prevention in NCPS. Some view this as lessening the perceived priority of HIV prevention, isolating sexual transmission from other modes of spread, and inappropriately imposing the operational model of STD control on HIV prevention. Another key question is how to strengthen the capability to do *good science* in the prevention program. Key activities that *should* be tied to prevention--disease monitoring, epidemiologic studies, laboratory investigation are situated in the NCID, which shares neither staff nor programmatic emphasis with NCPS. Broader ramifications at the non-federal level center on fragmented funding streams, barriers to integration, and a piecemeal approach to the work of prevention.

Although CDC's structure has been reviewed more than once over the past several years, the Committee members generally agree that another look is merited. Indeed, testimony from those working at the community level suggests that the current structure is sufficiently dysfunctional as to warrant immediate action. The CDC Director should seek the participation of affected constituencies--including state and local health departments and community grantees--in considering whether the current structure is optimal for meeting AIDS prevention needs.

SPECIFIC FINDINGS AND RECOMMENDATIONS

While acknowledging CDC's strong efforts to date, each of the five external review groups recommended some fundamental changes in the agency's approach to HIV prevention to understand and better respond to the national challenge of the HIV/AIDS epidemic. The following is a summary of their findings and recommendations.

Monitoring the Epidemic

The subcommittee found the AIDS case reporting system to be the main thrust of CDC's monitoring efforts, providing the only population-based data that are useful for evaluating disease prevalence by gender, race/ethnicity, age, and mode of exposure. Despite its continuing value as an information source, the system has limitations, most centering on the lengthy interval between HIV infection and AIDS. The subcommittee therefore recommended a *shift in emphasis toward the "front end" of the epidemic*--advocating a wider view of monitoring that includes precursors to AIDS, including sexual and drug-use behaviors.

Details of the subcommittee's review of CDC's efforts to monitor HIV-associated behaviors, occupational and nosocomial exposures and infections, the virus, HIV/AIDS incidence and prevalence, and HIV-associated morbidity and mortality can be found in the attached Subcommittee on Monitoring the Epidemic report. Key recommendations are that CDC should:

1. Coordinate a strategic plan to define the determinants of risk behavior and seek support at the highest level of government for its implementation, including reinstituting the National HIV Behavioral Risk Factor Surveillance Survey.
2. Conduct an ongoing, long-term, population-based national study of sexual and drug-use behaviors associated with HIV transmission.
3. Consolidate monitoring activities for occupational exposure to HIV with core hospital infection surveillance programs, and other monitoring systems.
4. Enhance efforts to identify incident HIV infections in affected communities and link incidence studies to behavioral data on HIV transmission risks through coordinated surveillance.
5. By use of more innovative cooperative agreements, improve the capability of local health departments and community organizations to determine the incidence and prevalence of HIV infection.
6. Define and enforce a strict confidentiality standard for reporting of HIV infection and AIDS.
7. Expand intramural and extramural laboratory and clinical research efforts to determine the relationship of different HIV strains to transmission and virulence.
8. Modify the "spectrum of disease" studies to detect differences in new populations at risk by weighted sampling. Integrate HIV infection surveillance with surveillance of opportunistic infections.
9. Speed the development and dissemination of prevention guidelines for opportunistic infections.

The group emphasized that enhanced and redirected monitoring activities at the community level must be accompanied by guaranteed access to appropriate care and treatment services for persons with HIV infection. Although this is not CDC's primary responsibility, improved access to care is another important step to enhance prevention opportunities. CDC should therefore assume an advocacy role for care and treatment to support its prevention efforts.

Improving Public Understanding of the Epidemic

The subcommittee reviewing NAIEP activities concluded that the goal of the early years of CDC's mass communication effort--to increase general awareness of AIDS--has been achieved. They therefore recommended a *shift away from the emphasis on the general public and toward specific populations at increased risk* of HIV infection. The urgent prevention needs of the second decade of the epidemic require provision of explicit, factual information targeted to persons at risk.

Recommendations related to NAIEP in general were as follows:

1. CDC should develop a strategic communications plan to set priorities for use of limited funds and ensure that programs are rooted in communication science and public health theory and practice.
2. Given that a hostile political environment has impeded an appropriate communications response, a) Congress must legislatively and fiscally empower CDC to carry out the strategic plan, b) CDC must be a more aggressive advocate for its own interests and for the public health science it represents, and c) the Secretary of Health and Human Services must become a more aggressive advocate for CDC's interests.
3. Criteria for developing risk-reduction messages should be developed and promulgated based on efficacious public health interventions, methods, and communications science.
4. Decision processes should reflect the magnitude and urgency of the HIV/AIDS crisis and the need for rapid responses.
5. CDC should involve affected populations in the development and implementation of the strategic plan.

The subcommittee also reviewed each of the eight NAIEP components. Although none was seen as unnecessary, the group determined that demands on many of the components had exceeded resources and that CDC needs to make difficult decisions about priority audiences and services. The recommendations for each component are included in the subcommittee's full report. Some key findings and recommendations are highlighted below.

1. National AIDS Clearinghouse services were determined to be underutilized because of lack of targeted promotion. CDC should refocus services to meet the needs of priority audiences, especially front-line community organizations.
2. National AIDS Hotline staff demonstrated impressive expertise and commitment. A concern was the difficulty in quickly assessing fast-breaking new items and generating responses to resulting peaks in usage. The main recommendation was to develop a long-term strategic plan to manage such peaks.

3. The America Responds to AIDS campaign, although acknowledged as contributing to public awareness, was seen as subject to political considerations that conflict with public health goals, not adequately targeted to people at highest risk, and only selectively based on prevention science. CDC was urged to broaden its media strategies beyond public service announcements. Media programs should be oriented toward risk education, with messages based on *specific methods* of demonstrated efficacy.
4. The public information components of the cooperative agreements with health departments could be improved by forming partnerships to integrate health communications, improve planning, minimize duplication, and make funding decisions.
5. National partnership agreements with CDC showed many strengths. Recommendations were to develop one strategic plan to direct these partnerships and to examine the role of funding.
6. Health communications efforts for minorities were seen as a weakness of the program. CDC should seek the assistance of minority advisory groups to enhance communications with diverse groups.

Preventing Risk Behaviors among School-Aged Youth

This subcommittee called for better coordination of CDC's youth-related programs and *expansion of the strategic plan for school-based programs to address the prevention needs of all young people*, in or out of school. A subtext was the ongoing problem of targeting. Both general prevention approaches and strategies for youth at high risk are needed in schools and elsewhere. Given insufficient funding for both, challenges remain in achieving the appropriate balance between general prevention and targeted approaches for youth.

In addition to a series of specific recommendations, the subcommittee had four core recommendations:

1. CDC's program for preventing HIV infection in youth is based on an existing strategic plan for school-based HIV education programs. CDC must now develop a national strategic plan to prevent HIV and related health risks among *all* youth by working not only with schools, but also with other youth-serving organizations, the media, and the business community. CDC should review its various youth-serving programs, with the intent of consolidating, or where consolidation is not practical, better coordinating youth initiatives.
2. CDC should continue to work through the schools to address HIV prevention directly, while also ensuring an integrated, comprehensive approach to preventing other HIV-related health problems in youth.

3. CDC should take immediate action to more substantially address the needs of youth at particularly high risk of HIV infection, whether they are in *or out* of school, including strategies for working with youth-serving agencies and organizations other than schools. This expanded focus should not detract from general school-based prevention strategies. Additional funding will be needed to adequately address both general school-based strategies and those targeted to youth in high-risk situations.
4. CDC should solicit broader, earlier, and more extensive input into program planning, implementation, and evaluation from direct-care providers, peer counselors, school health personnel, community groups, advocacy groups, young persons, and families.

Developing Partnerships for HIV Prevention

This subcommittee concluded that HIV prevention partnerships are not working as well as they should. Characterized by ill-defined goals, poor communications, lack of trust, and conflicting roles, they are further threatened by dwindling resources and competition for funding. Anger related to lack of technical assistance and confusion about CDC's role create additional barriers. Health departments, nongovernmental organizations, community-based organizations, and affected populations are all looking to CDC to *become a strong national advocate for HIV prevention and to provide the leadership, funds, skills, and training needed to forge effective, participatory partnerships*. The group's priority recommendations cover five areas of concern:

Leadership. Recommendations centered on the urgent need for CDC to take the lead in coordinating and integrating prevention services among federal agencies. CDC should articulate national HIV prevention goals "to restore itself to the high standards of science and to the legacy of commitment to the public health on which its reputation was built."

Communications. Four recommendations to improve communications among CDC, health departments, community organizations, and targeted populations focused on dispelling confusion about education versus prevention, articulating national prevention goals, clarifying roles and responsibilities, and ensuring cultural and linguistic appropriateness of prevention messages.

Equity. The group made a strong case for participatory planning. They stressed the need for mutual respect and meaningful communications to facilitate trust in partnerships, and emphasized that effective partnerships require time, direct contact, and a minimum level of core resources.

Funding. Among the recommendations in this area were that CDC should 1) tie equity in funding allocations to interventions that are effective for each targeted group, 2) guarantee increased funds to integrated prevention programs, and 3) provide funds for cross-training.

Coordination. CDC was urged to enhance coordination of HIV prevention activities by providing technical assistance, convening a multi-disciplinary task force to foster partnerships, and broadening the scope of prevention alliances.

The group identified barriers to and strategic needs for 1) enhancing partnerships, 2) forging effective alliances, 3) providing technical assistance, and 4) integrating services. "Turf" issues were found to impede collaboration at the community level; these need to be overcome at the federal level before they can be effectively addressed by state and local agencies. The subcommittee also identified new prevention partnership opportunities, with recommendations related to 1) rural areas, 2) border health issues, 3) correctional facilities, and 4) youth in high-risk settings.

Promoting Knowledge of Serostatus

The group disputed the view that the CTRPN program should be the cornerstone of the national effort to prevent HIV infection and raised questions about its emphasis, management, and effectiveness. They concluded that CTRPN programs generally do *not* comply with guidance issued by CDC. Moreover, even if CDC guidance were followed, with current resource levels and program structure, CTRPN programs would not be sufficient to change high-risk behaviors.

In their lengthy discussion of findings and recommendations, the subcommittee noted that HIV antibody testing has too often been erroneously equated with HIV prevention. While acknowledging the benefits of the HIV antibody test as a diagnostic tool to help infected persons obtain medical treatment, the group found its benefits as a prevention tool to be much less clear. Indeed, a negative HIV antibody test result may contribute to the continuation of high-risk behaviors by some persons. The key recommendation was therefore to *shift the emphasis away from testing as the main prevention intervention*. The two needed alternatives are 1) ongoing, individual-level behavior-change interventions for those at highest risk of HIV infection and those already infected, and 2) large-scale community-level interventions aimed at changing community norms.

The group recommended that CDC require that decisions about the relative role of CTRPN in the prevention mix be determined through a representative local process. Health departments, working with their communities, should have flexibility in determining the relative allocation of resources among the various components of the "continuum of prevention services." At the same time, the availability of anonymous testing services must be ensured.

Practical problems with the current CTRPN program were also noted. Suggested improvements included 1) ensuring professionalism in partner notification, 2) improving the current CDC structure for prevention, 3) improving quality assurance, and 4) ensuring access to care, including to prevention services.

CONCLUSION

The year-long external review documented by the following subcommittee reports represents an enormous effort by Advisory Committee members, consultants, and scores of volunteers who testified at site visits, attended meetings, and related their experiences with HIV prevention work in general and CDC programs in particular. Countless hours were also contributed by CDC staff, who were unfailingly cooperative and candid. The Committee thanks all who were involved.

CDC is to be commended for initiating and supporting this unprecedented effort. It is evident that the subcommittees' findings and recommendations have been taken seriously, and many have already been acted upon. The Committee looks forward to the agency's response to this report and intends to work to improve CDC's role as a leader in and advocate for HIV prevention.

The past 13 years are seen by many as being marked a national failure to recognize the impact of the HIV/AIDS epidemic, to mobilize prevention partnerships and resources effectively, and to act decisively to halt the spread of HIV infection. Against the backdrop of an expanding and still uncontrolled epidemic, tight resources, and a legacy of restrictive policies, CDC's prevention program continues to evolve. This external review is the first step in what the Committee hopes will be a continuing process of assessment and "course correction."

Unfortunately, the structure of the review precluded an analysis of CDC's *overall* approach to HIV prevention: the plan, the objectives, the acceptable outcomes, the components of the prevention mix that are (and are not) achieving success. Such an analysis is a logical--and necessary--next step. Although much has been done to understand the dynamics of the epidemic and to intervene to control its spread, the struggle is far from over. And the most difficult part surely lies ahead.