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Subseries: National AIDS Strategy

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Folder Title:
ONDCP [Office of National Drug Control Policy] [2]

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EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20500

JUN 30 1995

MEMORANDUM FOR PATSY FLEMING

FROM: FRED GARCIA

SUBJECT: ONDCP NATIONAL AIDS PLAN

At your request, please find attached a plan reflecting the ONDCP goals and objectives in combatting AIDS. In response to the Office of National AIDS Policy's guidance, for each goal ONDCP states objectives, action steps, programs that implement the actions steps (including a description of the program, resources in the FY 1995 estimated budget and FY 96 proposed budget, population served, and constituency involvement in development of the program), and the unmet need. If you have any questions, please contact me at 395-6601.

ATTACHMENT

Barbara Roberts
7th floor
395-6601

OFFICE OF NATIONAL DRUG CONTROL POLICY
HIV/AIDS PLAN

"STRENGTHENING COMMUNITIES' RESPONSE TO ILLICIT DRUG USE AND HIV/AIDS"

HIV/AIDS, according to the Office of National AIDS Policy, is the number one public health emergency in the country. Everyday, the disease affects more people in more communities. Efforts art research, prevention and treatment are making progress. The Administration remains committed to the fight and will resist any effort to reduce the resources devoted to AIDS.

President Clinton has pledged a "loud, clear, and consistent war on AIDS." He has reenergized the Federal response and urged all Americans to do their part in caring for people with AIDS and responding in their local communities.

The Office of National Drug Control Policy strongly bases the need for programs for the hardcore addict on the fact that an epidemic exists between illicit drug use and HIV/AIDS. HIV can be transmitted through injection drug use when the blood of an HIV-infected drug user is transferred to a drug user who is not yet infected. However, chronic, hardcore drug users, especially of cocaine, also exhibit high-risk sexual behaviors that are associated with transmission of certain diseases.

In a recent study of 222 African-American teenage users of crack and other drugs in San Francisco, researchers found that 96 per cent of them were sexually active. About half of the teens reported engaging in sex after smoking crack and most (77 per cent) of them did not use a condom the last time they had sex. Currently, one-fifth of all people with AIDS are between the ages of 20 and 29.

The facts provided by the Centers for Disease Control and Prevention cannot be ignored and the data indicates that the problem for addicts is getting worse. Of the 47,106 AIDS cases in 1992 in the United States, Puerto Rico and the territories, 16,218 (43 per cent) were associated with intravenous drug users (IDUs). In 1994, IDUs comprised more than 50 per cent of all AIDS cases reported. ONDCP is also well aware that major differences exists in HIV/AIDS rates for different regions of the country.

TARGETING CHRONIC, HARDCORE DRUG USERS, AND THEIR CHILDREN

Chronic, hardcore drug use is clearly related to the high levels of crime, health problems, and violence in cities, towns, and neighborhoods across the Nation. The immediate priority of the ONDCP Strategy, therefore, is to target the problems created by this population of drug users. The following evidence supports this prioritization:

0 Drug use is straining the Nation's health care system. The costs of treating drug users are passed on to hard-working Americans through increased insurance premiums. In 1993 almost 500,000 drug-related emergencies occurred nationwide. More than one-third of all AIDS (Acquired Immune Deficiency Syndrome) cases were associated with the reckless, self-destructive behavior of drug users.

0 Chronic, hardcore drug users account for two-thirds of the total amount of cocaine consumed in the United States, even though they comprise only 20 percent of all cocaine users. Therefore, it is the chronic, hardcore drug users who keep the major drug traffickers in business.

0 Chronic, hardcore drug use causes severe and long-term health consequences. A Department of Health and Human Services (HHS) study of the record number of heroin medical emergencies in 1993 suggests that prolonged heroin use produces cumulative adverse health effects.

0 When a user is going through periods of heavy or addictive drug use, the frequency and severity of his or her criminal activity rises dramatically. Drug-related criminal activity is one of the main reasons for the substantial growth of U.S. prison and jail populations.

TREATMENT FOR HARDCORE DRUG USERS WITH HIV-AIDS: THE ONDCP RESPONSE

When effectively administered, drug treatment can reduce the level of use, as well as the consequences of illicit drug use, including HIV-AIDS. It has been proven that when drug-dependent individuals receive appropriate treatment, they decrease their drug use, decrease their criminal activity, increase their employment, improve their social and interpersonal functioning, and improve their physical health.

Reducing health care costs created by illicit drug use requires a comprehensive response. First, drug prevention efforts must increase their focus on populations who are at risk for drug use. Making individuals aware of the health consequences of illicit drug use may ultimately prevent the onset or continuation of chronic, hardcore drug use and related health-threatening behaviors. Second, the chronic, hardcore drug users, who are suffering the health consequences of prolonged drug use, must be provided access to effective treatment for their addiction and related health problems.

Numerous studies confirm the fact that treatment of chronic, hardcore addicts, both within the correctional setting and in community-based programs, is the most cost effective response and the course of action that makes the most practical sense.

As a specific goal, ONDCP will work with congress, to secure an additional
$100,000,000 to treat more addicts than we can with current resources.
As $60.0 million is scheduled to be rolled into the Block Grant to states, ONDCP will also work with State Alcohol and Drug Authorities and their respective Governors' Offices to ensure these resources are indeed used for the chronically addicted.

In 1994 the Department of Health and Human Services (HHS) continued its major linkage effort, first launched by the Center for Substance Abuse Treatment in 1993. The program links community-based primary care, substance abuse, HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome), and mental health services. So far projects have been funded in 10 States and the District of Columbia, with most of the programs targeting substance-abusing and homeless women as a key population. ONDCP will continue to support and advocate for this innovative project.

PREVENTION OF DRUG USE AND ITS CONSEQUENCES

The Federal Government can best provide leadership to this initiative by modeling collaboration and joint planning among the 32 Federal agencies with demand reduction responsibilities. ONDCP will lead this effort by convening a round table discussion of demand reduction agencies as part of the NDPS. The NDPS will provide an inventory of existing drug abuse prevention initiatives and programs, identify major gaps and areas of overlap, and plan the most effective use of resources. Major prevention agencies in the Departments of Education, Health and Human Services, Justice, Housing and Urban Development, and Labor, as well as planning and coordination agencies such as ONDCP, the Office of National AIDS Policy Coordination, and National Performance Review will be involved. The NDPS also will report to the President's Ounce of Prevention Council and will be chaired by ONDCP's Office of Demand Reduction.

The NDPS will include the following ongoing and new initiatives:

0 Encouraging private-sector drug prevention organizations to share information and work together to heighten prevention efforts nationwide, including efforts aimed at HIV-AIDS prevention;

0 Encouraging community-based prevention services in all communities to include services for youth at risk for drug use and HIV-AIDS;

0 Encouraging community partnerships to coordinate prevention programs at the local level so as to provide comprehensive services throughout communities inclusive of the HIV-AIDS message;

0 Supporting State organizations to provide a statewide network of community partnerships;

0 Convening a forum to address national prevention policy matters, including the drug use / HIV-AIDS connection;

0 - Local prevention providers will be encouraged to serve children of addicted parents to stop the intergenerational nature of addiction;

0 - Sanctions will be developed for those individuals who are enrolled in a criminal justice system treatment program and who fail to move toward abstinence; and

0 - Those not involved in the criminal justice system will be identified though various outreach programs (e.g., AIDS outreach) for drug treatment. A neutral party will monitor the individual to ensure that all services are being used to assist him or her in becoming drug free.

0 ONDCP will produce and distribute a directory titled Anti-Drug Programs That Work at the Community Level.

ATTACHMENT A

Area: Treatment
Goal: REDUCE THE NUMBER OF HARDCORE ADDICTS

ONDCP National HIV/AIDS Plan
June 30, 1995

Objective	Action Steps	Programs					Unmet Needs
		Descriptions	Resources		Populations Served	Constituency Involvement	
			FY 1995	FY 1996 (proposed			
Reduce the number of IDU and cocaine hardcore addicts with high risk sex practices, 20% by 1997.	* Encourage private-sector drug treatment organizations to share information and work together to heighten treatment efforts nationwide, including efforts aimed at HIV/AIDS treatment. * Encourage community-based treatment services in all communities to include services for drug use and HIV/AIDS. * Support State organizations to provide a statewide network of community treatment partnerships. * Convene a forum to address national treatment policy matters, including the drug use and HIV/AIDS connection. Guidelines submitted to communities receiving Substance Abuse Performance Partnership funds.	ONDCP'S HIV/AIDS plan consists of the development of the annual National Drug Control Strategy, which includes treatment of illicit drug use related to co-morbid disorders, i.e., HIV/AIDS.	1.6 million	$1.6 million	2.7 million, at risk.	Community partnerships	Reduction plan targets approx. 20% of the population during the coming fiscal year.

ATTACHMENT A

Area: Prevention
Goal: REDUCE THE NUMBER OF NEW HARDCORE ADDICTS

ONDCP National HIV/AIDS Plan
June 30, 1995

Objective	Action Steps	Programs					Unmet Needs
		Descriptions	Resources		Populations Served	Constituency Involvement	
			FY 1995	FY 1996 (proposed			
Reduce the number of IDU and cocaine hardcore addicts with high risk sex practices, 20% by 1997.	* Encourage private-sector drug treatment organizations to share information and work together to heighten treatment efforts nationwide, including efforts aimed at HIV/AIDS treatment. * Encourage community-based treatment services in all communities to include services for drug use and HIV/AIDS. * Support State organizations to provide a statewide network of community treatment partnerships. * Convene a forum to address national treatment policy matters, including the drug use and HIV/AIDS connection. Guidelines submitted to communities receiving Substance Abuse Performance Partnership funds.	ONDCP'S HIV/AIDS plan consists of the development of the annual National Drug Control Strategy, which includes treatment of illicit drug use related to co-morbid disorders, i.e., HIV/AIDS.	1.6 million	$1.6 million	2.7 million, at risk.	Community partnerships	Reduction plan targets approx. 20% of the population during the coming fiscal year.

To Jeff Levi

Date 7/10/96 Time 10:25

WHILE YOU WERE OUT

M Rica McMahon

of

Phone 395 6706
Area Code Number Extension

TELEPHONED	✓	PLEASE CALL	✓
CALLED TO SEE YOU		WILL CALL AGAIN	
WANTS TO SEE YOU		URGENT	
RETURNED YOUR CALL			

Asap

Message (1) Barbara Roberts responsible for clearing intent. 395 6601
(2) Other budget questions & who served on IDTF from Treasury.
-DSDarden-
Operator
Related to document.
(3) Enumerate short questions about what they can & cannot do.
"Answering questions in a vacuum not knowing, or working, in tandem with HHS."
(4) Know Patsy's intent.
(5) What "is" "Theodore-Mark"

AMPAD EFFICIENCY® 23-023 CARBONLESS

To

Date Time

WHILE YOU WERE OUT

M

of

Phone
Area Code Number Extension

TELEPHONED		PLEASE CALL	
CALLED TO SEE YOU		WILL CALL AGAIN	
WANTS TO SEE YOU		URGENT	
RETURNED YOUR CALL			

Message (Ken)
(6) Who from this office provided info & #s in what is already there. etc, etc, etc.
Please call
Operator

AMPAD EFFICIENCY® 23-023 CARBONLESS

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

July 22, 1996

MEMORANDUM

TO: CHIEF OF STAFF

THRU: JOHN CARNEVALE
JOHN GREGRICH

FROM: BARBARA T. ROBERTS

SUBJECT: ONDCP STATEMENT FOR SUBMISSION IN THE OFFICE OF NATIONAL AIDS POLICY PLAN

The following statement has been drafted for inclusion in the Office of National AIDS Policy Plan. The finalized version of the Plan is due to go to press this evening. Ricia McMahon has read and given feedback on this statement:

STATEMENT

The White House Office of National Drug Control Policy is a partner with the Office of National Strategy for HIV and AIDS Policy. This partnership between offices results from efforts to develop strategies to effectively counter the problems of substance abuse and HIV/AIDS, and the devastating consequences caused by the interlink between two conditions that have contributed to the destruction of so many American lives. To this end, the theme of the 1996 ONDCP Strategy is "Reducing Drug Use and Its Consequences in America." The five goals of this Strategy are:

1. **Motivate America's youth to reject illegal drugs and substance abuse.**

2. **Increase the safety of America's citizens by substantially reducing drug-related crime and violence.**

3. **Reduce health, welfare, and crime costs resulting from illegal drug use.**

4. Shield America's air, land, and sea frontiers from the drug threat.

5. Break foreign and domestic drug sources of supply.

There are 2.6 million chronic drug users who are at high risk of contracting HIV/AIDS. Chronic drug users also engage in sexual behaviors that put them at high risk for contracting and spreading sexually transmitted diseases. Reducing the number of chronic addicts, and accompanying risks behaviors, has been determined as critical to the mission of ONDCP.

ONDCP has the regulatory responsibility to coordinate the policies, objectives, priorities and budgets of 52 Federal agencies including many agencies within the Department of Health and Human Services (DHHS). The ONDCP director can decertify an budget if it fails to comply in implementing the goals as specified by the President and ONDCP.

This Office will continue to work collaboratively with the AIDS Policy Office and other Federal, state and community agencies and services to reverse the devastation caused to Americans by these scourges.

---------End of Statement----------

- HIV prevention lens.

THE WHITE HOUSE
WASHINGTON

hand carried 4/10/96 12:05pm

Barbara Roberts

1) OMB text revisions
2) HHS Appendices
3) Fred Garcia

7th floor

395-6601

July 9. 1996

Copies of documents hand carried to ONDCP June 17. (R. Rowoche)

Hand carried again 7/9/96. (S. Darden)

June 12, 1996

MEMORANDUM FOR THE INTERDEPARTMENTAL TASK FORCE
OFFICE OF NATIONAL DRUG CONTROL POLICY

FROM: Patricia S. Fleming
Director, Office of National AIDS Policy

SUBJECT: Review of Draft of the National Strategy for HIV and AIDS

As a result of our meetings last year each member of the Interdepartmental Task Force on HIV/AIDS (IDTF) was asked to develop individual department and agency plans for HIV/AIDS, linking goals and objectives to budget levels and identifying areas of unmet need.

The individual plans you submitted were carefully studied. This past February, IDTF members reviewed the draft and provided comment. We are in the final stages of revising the document as informed by this review, and, updating budget figures.

Attached is the revised draft of the National Strategy for HIV and AIDS. Please review the attached draft and your appendix carefully. You should:

- Update the budget table to reflect current figures, noting FY 95 actuals, FY 96 estimates, and the FY 97 President's budget request for each agency goal. (These budget figures will be cross-checked with OMB figures.) The attached table reflects the budget levels provided in your revised submission.

- Information that was missing or unclear has been 'redlined'. Please be certain to provide this information.

- Check for the accuracy of department and agency names, program titles, and acronyms.

- Make sure that your comments are clear and specific. Comments are due back to the Office of National AIDS Policy **BY NO LATER THAN JUNE 21, 1996.** If you have any questions please call Jane Sanville at (202) 632-1090.

Thank you for your assistance in developing this first-ever National Strategy for HIV and AIDS.

Attachments: The National Strategy for HIV and AIDS, 6.11.96 draft
ONDCP Appendix for The National Strategy for HIV and AIDS, 6.11.96 draft

June 12, 1996

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ONDCP Appendix for The National Strategy for HIV and AIDS, 6.11.96 draft

Area	Objective	FY 95 Actuals	FY 96 Estimate	FY 97 President's Budget
Treatment	Reduce the number of injection drug use and cocaine addicts with high risk sex practices 20 percent by 1997.	$1,600,000	$1,600,000	
Prevention	Reduce the number of injection drug use and cocaine addicts with high risk sex practices 20 percent by 1997.	$1,600,000	$1,600,000	

Unmet Need: Reduction plan targets approximately 20 percent of the population during the coming fiscal year. Twenty percent of which population?

PREVENTION

Agency: Office of National Drug Control Policy

Goal: Reduce the number of new hardcore drug addicts.

Objective: Reduce the number of injection drug use and cocaine addicts with high risk sex practices 20 percent by 1997.

What the base figure the 20 percent reduction is based on?

Action Steps: Encourage private sector drug treatment organizations to share information and work together to heighten treatment efforts nationwide, including efforts aimed and HIV/AIDS treatment.

Encourage community-based treatment services in all communities to include services for drug use and HIV/AIDS.

Support state organizations in providing a statewide network of community treatment partnerships.

Convene a forum to address national treatment policy matters, including the connection between HIV/AIDS and drug use.

Provide guidelines on ??? to communities receiving Substance Abuse Performance Partnership funds.

Descriptions: Substance Abuse Performance Partnership Program. In addition, ONDCP's annual National Drug Control Strategy includes treatment of illicit drug use related to co-morbid disorders such as HIV/AIDS.

FY 95: $1,600,000
FY 96: $1,600,000 Does the $1.6 million cover both treatment and prevention? Or is the total for both treatment and prevention $3.2 million? Is this program co-funded with any other departments or agencies?

Populations Served: 2.7 million, at risk. Are these persons enrolled in ONDCP-sponsored programs?

Constituency Involvement: Community partnerships. Any examples of groups involved?

TREATMENT

Agency: Office of National Drug Control Policy

Goal: Reduce the number of current hardcore drug addicts.

Objective: Reduce the number of injection drug use and cocaine addicts with high risk sex practices 20 percent by 1997.

What the base figure the 20 percent reduction is based on?

Action Steps: Encourage private sector drug treatment organizations to share information and work together to heighten treatment efforts nationwide, including efforts aimed and HIV/AIDS treatment.

Encourage community-based treatment services in all communities to include services for drug use and HIV/AIDS.

Support state organizations in providing a statewide network of community treatment partnerships.

Convene a forum to address national treatment policy matters, including the connection between HIV/AIDS and drug use.

Provide guidelines on ??? to communities receiving Substance Abuse Performance Partnership funds.

Descriptions: Substance Abuse Performance Partnership Program. In addition, ONDCP's annual National Drug Control Strategy includes treatment of illicit drug use related to co-morbid disorders such as HIV/AIDS.

FY 95: $1,600,000
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Populations Served: 2.7 million, at risk. Are these persons enrolled in ONDCP-sponsored

programs?

Constituency Involvement: Community partnerships. Any examples of groups involved?

Unmet Need: Reduction plan targets approximately 20 percent of the population during the coming fiscal year. Twenty percent of which population?

Ricia:

This section is FYI – as per Jeff Sir.

II. OVERVIEW OF FEDERAL EFFORTS

Introduction

The scope and nature of the HIV/AIDS epidemic have brought State, local, and Federal involvement into many HIV-related activities. The Federal government, through its public health responsibilities in such areas as research, prevention, health care, and housing has seen a dramatic increase in its activities since the beginning of the epidemic. In 1985 the Federal government spent $212 million for AIDS research, surveillance, and care. With the dramatic increase in cases, by 1995 that figure had reached $6,848 million. (See Appendix G). Congress also took note of the rapid increase in cases of HIV and AIDS and passed legislation that sought to address the needs of HIV-infected persons and their families, and the Nation's need to find a cure and a vaccine, including the Ryan White Comprehensive AIDS Resources Emergency Act (CARE) Act and the NIH Revitalization Act of 1993.

Currently, Federally sponsored activities include direct support for research, prevention and education, housing, medical care, support services, information dissemination, enforcement of civil rights, and assistance to international organizations and other nations. While Federal Agencies are responsible for responding directly to the epidemic of HIV and AIDS, they also collaborate with and provide support for State and local governments, academic institutions, private foundations, health care institutions and community-based organizations, which often have substantial surveillance, prevention, and health care responsibilities.

PREVENTION

The Nation's prevention goal is to develop effective prevention strategies that will reduce the number of new infections each and every year until there are no new infections. Achieving this goal will require a dedicated alliance between the Federal government, States, local governments, communities, businesses, non-governmental organizations, families, and individuals. Achieving this ambitious end will require a clear definition of the different roles and responsibilities of the Federal government, and an ongoing dialogue with its partners in the public and private sectors about the responsibilities each has in reaching this goal.

We know that HIV prevention works. We also know that the task of preventing HIV transmission faced by the United States in controlling the epidemic of HIV and AIDS has reached enormous proportions.[12] The Centers for Disease Control and Prevention (CDC) estimates that approximately 800,000 to 1 million Americans are presently HIV-infected, many of whom are unaware of their HIV status. Moreover, the CDC estimates that approximately 40,000 to 60,000 American will become infected each year. Many more Americans who are not presently infected are at risk for acquiring HIV. HIV infection is a unique prevention challenge because of the virus' virulence, the long period of time when people may not be aware they are infected, long duration of infectiousness, nearly always fatal prognosis, and potential for exponential spread. Moreover, HIV is transmitted primarily as a result of personal and private individual behaviors -- sex and drug use. To be effective, HIV prevention programs must reach tens of millions of Americans who are characterized by a diversity of age, race, ethnicity, geographic locale, sexual orientation, and sexual and drug use behaviors.

Prevention activities are currently supported by several Federal Agencies. (See Appendix A.) Most Federal prevention efforts are funded by Department of Health and Human Services (HHS), although other Departments such as the Department of Defense (DOD), and the Department of Veterans Affairs (VA) also support prevention activities. These efforts reflect a continuum from surveillance to research to social marketing initiatives. Agency activities are also reflective of their respective missions. For example, the Centers for Disease Control and Prevention (CDC), the Agency with primary Federal HIV-prevention responsibilities, supports a wide range of surveillance and prevention projects, many in partnership with States, local governments, and community-based organizations. Other Agencies focus on specific aspects of prevention. For example, the National Institute on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMSHA) support efforts to prevent HIV infection among drug users, while other Agencies support primary prevention efforts as part of medical care, such as at the veterans and military hospitals and clinics. The Health Resources and Services Administration (HRSA) also encourages

broader access to prevention information through the integration of prevention interventions into primary health care services and through support of early intervention services for low-income medically underserved persons. HRSA also has undertaken special initiatives designed to reduce perinatal transmission of HIV and has promoted primary prevention through the training of health professionals in the AIDS Education and Training Centers program.

The efforts of Federal Agencies as well as research conducted at universities and private organizations, have been instrumental in expanding our knowledge base about HIV prevention. However, significant gaps remain. We know from both formal research and community experience that developing prevention programs that are effective requires knowledge of who is becoming infected and of the behaviors that are enabling transmission, an understanding of the motivations for those behaviors, and an understanding of how best to reach people with messages that will ensure lasting behavior change.

Prevention priorities must be guided toward gaining knowledge that will improve our efforts to develop effective prevention programs. We need to improve our understanding of the major modes of transmission, close gaps in scientific knowledge, including identifying effective prevention models and strategies, and work towards eliminating gaps in program areas.

Opportunities for Progress

Modes of Transmission

An important part of strengthening prevention activities is to have a clearer understanding of who is being infected and what behaviors are placing people at risk for infection. Recent epidemiologic data show that the HIV epidemic continues to spread in the United States among people who engage in injection drug use and their sexual partners, young and minority men having sex with men, heterosexual transmission, and through perinatal transmission. Moreover, the youth of our country are becoming infected at an alarming rate -- 50 percent of new infections in the United States are in persons under 25 years of age. HIV is the leading cause of death in Americans aged 25 to 44 and it is likely that many of these people were infected while they were adolescents. Racial and ethnic minorities are also disproportionately represented among new HIV infections. As of October 1995, African-Americans accounted for 38 percent of newly reported AIDS cases and Hispanics represented 18 percent of new cases. These trends in the epidemic must be taken into consideration when prioritizing prevention research and service programs.

A crucial part of effective prevention strategies includes supporting adequate surveillance of HIV infection and related diseases in order to gauge future directions of the epidemic, and assess the effectiveness of prevention interventions. As previously

noted, the CDC is the Federal Agency with primary responsibility for monitoring the epidemic. Seroprevalence surveys provide information on the level of HIV infections in "sentinel" populations. The CDC AIDS case and case death reporting system provides useful data for assessing AIDS prevalence and mortality by gender, race/ethnicity, age, and mode of exposure. This surveillance system also provides essential data on HIV-related opportunistic infections.

There are, however, opportunities for refinement. Effective prevention intervention programs begin with sound information on who is at risk. Current CDC surveillance systems do not capture sufficient "front-end" information on the incidence and prevalence of HIV (not AIDS) in the population, and trends in modes of transmission and new infections. Collection of these data are needed as part of an enhanced effort to link surveillance and epidemiological data to priority setting, in addition to the design and evaluation of prevention programs. (These data must be collected with the appropriate confidentiality protections.)

The CDC has recognized the value of this approach and has incorporated data collection design into its community planning process. These shifts in data needs coupled with fiscal restrictions may also require that the CDC reevaluate and reconfigure its data collection efforts. As part of the Agency's implementation of the recommendations set forth in the external review of CDC's HIV prevention strategies[13], the CDC has initiated efforts to evaluate current data collection efforts and implement necessary changes, and this work should continue.

Prevention Research[14]

Factors that place individuals at risk for acquiring HIV infection are a complex combination of behavioral, social, cognitive, and biological influences. Given this complexity we must not *assume* we intuitively know which interventions will work, but instead base our efforts on sound research findings and evaluation. Experience has taught us that prevention efforts can be effective, but when they are it is because the intervention incorporates findings from both experience and relevant research. Behavioral research is a relatively young science and there are currently more questions than answers. The three main areas where gaps in knowledge have been identified are basic behavioral research, intervention research, and social marketing research.

Basic Behavioral Research. Information provided by the conduct of basic behavioral research should serve as the foundation for prevention programs. Basic behavioral research, similar to basic research in other areas of scientific inquiry, seeks to explain the determinants and causes underlying biological, behavioral, and social processes. HIV-related risk-taking behavior is often complex and influenced by a host of individual and environmental factors.

To capitalize on what is known and improve

HIV prevention programs that are targeted to reach a diversity of Americans, more information on the determinants of HIV-associated sexual and drug-using behaviors is needed. For example, although much has been learned about the basic biology of substance abuse, further elucidation of the mechanisms underlying addictive behavior may assist in the development of new therapeutic approaches to addiction, which may in turn reduce the number of new infections.[15] And although we have some information on relevant risk-taking behaviors, more information about knowledge, attitudes, decision-making processes, and beliefs about AIDS and other sexually transmitted diseases (STDs) is much needed. Such data enable scientists to establish theories of behavioral change, which then provide researchers with tools for identifying what approaches may be most effective for an individual or a community.[16] [Awaiting revised language from NIH.]

Intervention Research. A second major gap is research to improve prevention interventions, i.e., research that concentrates on modifying behaviors, such as those related to drug use and sexual practices. We know from other behavior-influenced diseases (such as hypertension) and practices (such as cigarette smoking and wearing seatbelts) that basic information about what motivates a person to exhibit these behaviors can be incorporated into intervention research to advance approaches to reducing unhealthy behaviors.

In HIV and AIDS, this intervention research can focus on both individuals and communities, which often hold norms that influence personal behavior. Since the beginning of the epidemic we have made advances in our understanding of factors that are relevant to the design of intervention programs intended to reduce rates of HIV infection. This theoretically based intervention research has identified several significant predictors of changes in sexual and drug-using behaviors among gay men, adolescents, and heterosexual adults.[17] Studies have shown that community-based HIV risk reduction programs that are gender relevant and culturally sensitive can be effective.[18] A recent study has also provided a reason for optimism that the spread of HIV can be contained among injecting drug user populations when there is early community outreach and access to sterile injection equipment.[19]

However, despite this evidence of success, there is more that we need to know if we are to develop effective prevention programs for a diversity of Americans. We must incorporate findings from basic behavioral research into effective prevention interventions. One high priority area is research on interventions that lead to sustained behavior change and reduced recidivism. Another area for investment is research on cultural barriers and strategies to reach populations resistant to certain behavior interventions. A third area is research on the effectiveness of treatment for drug abuse, mental illness, and alcoholism in reducing HIV risk behavior.

Agencies supporting intervention and

behavioral research must include scientists from a broad range of disciplines in their planning activities and improve their data-sharing and collaborative efforts with Agencies responsible for implementing prevention programs. Enhancing the dialogue between researchers in these two related fields will invariably improve the development of effective prevention interventions.

Social Marketing Research. It is important that the findings from basic behavioral and intervention research be incorporated into prevention programs. Agencies supporting social marketing activities need to build on current knowledge in addition to strengthening efforts to understand barriers to the implementation and replication of promising prevention programs. Given the highly innovative nature of these endeavors, the CDC must consider providing broader technical assistance and training to community organizations. Moreover, a community-based effort that would test prevention models in a real-world setting should be carefully considered. [Awaiting additional language from NIH.]

We know from efforts in other countries that HIV-related social marketing efforts can be successful. However, we have not been as effective as we could be in disseminating information about effective strategies so that this knowledge can be employed in the design and implementation of prevention interventions. There *are* good models for prevention interventions that are not making their way to those on the front lines of the epidemic. Community-based organizations, which are responsible for developing a large portion of the prevention programs often do not, or are not able to, take advantage of current knowledge about program effectiveness.

Prevention Programs

In order to stop new infections, the results of basic behavioral, intervention and social marketing research must serve as the foundation for prevention intervention programs that reach people at risk for acquiring or transmitting HIV. Presently, the Federal government supports a range of programs that address the disparate needs of a number of at-risk populations. However, the shifting demographics of the epidemic coupled with restricted resources has resulted in gaps in program areas that limit the Nation's ability to prevent new infections. It is therefore important that prevention planners carefully prioritize their efforts based on local epidemiology.

Community Involvement. For prevention interventions to be effective they must reach communities at risk and be responsive to their unique needs. And for individuals to take control of their own lives in fighting the spread of this virus, they must first have the information and skills to protect themselves.

One of the most important innovations in the prevention area is community planning. The community planning process is an outstanding model of a Federal-local partnership. Through this effort, it is possible to establish joint goals for the

prevention of HIV that will meet Federal standards while remaining responsive to local needs. However, this process is early in its development and requires significant, ongoing leadership and technical assistance from the CDC if it is to fulfill its potential for good priority setting and decision making.

Substance Abuse Prevention and Treatment. Injection drug use is one of the major forces driving the epidemic with one third of all new cases are directly or indirectly related to this mode of transmission. Limiting the impact of substance abuse on the epidemic will require efforts on several fronts.

First, we need to improve the integration of HIV prevention activities and substance abuse treatment and prevention programs. The epidemics of substance abuse and HIV in this country are overlapping and highly interrelated, however, care and prevention services for HIV and substance are not. It is vital to continue efforts to integrate HIV prevention into current substance abuse programs and integrate substance abuse prevention into HIV prevention.

A second avenue for controlling the spread of HIV among addicted persons is enrollment into drug treatment programs. Substance abuse treatment is a form of HIV prevention. Moreover, substance abuse problems that contribute to the spread of HIV are not limited to injecting drug use. There is substantial evidence that use of alcohol and other substances can adversely influence risk-taking behavior. In addition, it is estimated that [redacted] percent of the population is affected by alcohol abuse and other non-injectable drugs.

Fundamental to the success of an integrated approach would be the continued expansion of educational activities to prevent substance abuse, and increased outreach efforts to encourage active substance users to seek treatment. We also need to ensure that drug treatment services are available in sufficient numbers for a range of addictions for those in need of such services. This would include services that accept pregnant women or women with children, indigent members of the community and adolescents.

Work on this issue has begun and will continue. The CDC has an initiated State-by-State discussion, including meetings with State Legislators, regarding HIV prevention issues. The CDC is also working with the National Conference of State Legislatures to provide a forum for a broad spectrum of views on this important issues.

Treatment for Sexually Transmitted Diseases and Tuberculosis. Studies have shown that the presence of sexually transmitted diseases (STDs) can significantly increase the efficiency of HIV transmission, even by as much as 20 times. Studies have also shown that widespread treatment of STDs in certain communities has led to a 40 percent reduction in new HIV infections in these groups.[20],[21] These data suggest treating STDs can be an effective HIV prevention strategy and points to a need for all clinicians to be vigilant in efforts to prevent and treat STDs.

Persons who are HIV positive are at significant risk for developing of *M. tuberculosis* (TB) disease. Studies suggest that the risk of developing TB disease is 7 to 10 percent each year for persons who are infected with both TB and HIV, whereas the risk is 10 percent over a lifetime for persons not infected with HIV.[22] In addition to the health implications for infected persons, there is an increased risk of transmission of TB to household members, health care workers, and other persons having regular contact with the person with TB.

It is important that Federal and State efforts to reduce the incidence of sexually transmitted diseases (STDs) include an HIV prevention element, and, that HIV prevention programs incorporate STD prevention and treatment efforts. Moreover, the traditional model of targeting most STD prevention efforts towards individuals who have already contracted one STD is not necessarily effective for HIV prevention. Enhanced and innovative linkages between STD and HIV prevention need to be established. The newly organized National Center for HIV/STD/TB Prevention at CDC reflects the importance of integrating these inter-dependent aspects of the epidemic and illustrates our determination to integrate and coordinate HIV, STD, and TB programs.

Integration Into Primary Care. To reach our prevention goal, we must also improve the integration of prevention activities and messages into primary health care services. HIV counseling and voluntary testing often provide an important bridge between HIV prevention and care for many at risk persons, including youth, women, and ethnic minorities. To assure that all persons seeking HIV testing can have access to such services, the CDC's counseling and testing guidelines should acknowledge and address the needs of persons seeking such services, and provide training for personnel at CDC-funded sites.

Incorporating a patient's sexual and drug using history when a medical history is taken, offering HIV-related counseling and voluntary testing, and working with HIV positive individuals so they do not infect others is also important. It also means offering pregnant women information about and access to AZT during pregnancy to reduce the risk of perinatal transmission. Training should be made available to improve primary care providers' skill, comfort level and sensitivity in these areas.

Achieving this level of integration will require active collaborative efforts on the part of individual physicians, nurses, other clinicians, managed care plans, medical schools, and professional organizations in addition to State, local, and Federal governments.

Prisoners. Populations in prisons are at high risk for both substance abuse and HIV disease. Moreover, there is often a high prevalence of both HIV and substance abuse behaviors in people entering prison.

Given that the incarcerated population is often at increased risk for HIV infection, offering educational programs during incarceration provides a unique opportunity

to reach these persons. Studies have found that programs using peer counselors have been effective in delivering HIV treatment and prevention messages. Research has also shown that individuals who are well informed about HIV and substance abuse issues do modify their risk-taking behaviors. It is important the Federal government build upon the knowledge and opportunity that currently exists and further improve HIV prevention efforts for incarcerated persons.

Evaluation. It is important to assess the effectiveness of the prevention interventions that have or will be implemented. Prospectively set performance measures can be used as a basis for evaluation and program improvement. Incorporating effectiveness measures must become a routine part of all Federally-funded programs. It is only through sound evaluations that we will be able to determine whether our efforts have been effective in slowing the epidemic. Achieving this will also require careful examination of what programs should be continued, what activities need to be initiated, and a awareness that a reconfiguration of some program priorities may be required.

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