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cc SD

EXECUTIVE OFFICE OF THE PRESIDENT

29-Jun-1996 01:32pm

TO: whitescj@od31em1.od.nih.gov@INET
FROM: Ursula Sanville
AIDS Policy Council
CC: Jeffrey Levi
SUBJECT: NIH appendix

Hello Jack --

I wanted to follow-up on two things to our conversation yesterday. In the unmet need section, Wendy and I had agreed to noting the dollar difference between the bypass budget and the President's budget for each area of emphasis (i.e. natural history and epidemiology, therapeutics, vaccines, etc.) along with text indicating that 'these funds represent precious resources but could be well-used in the NIH research effort.' We need the precise language NIH would like to use in each unmet need section.

Also, when you send the appendix, it would help us tremendously if it's in WP 5.1. for DOS.

Again, the contact person is Sherry Darden. Thanks much for your help.

Jane

cc SD
after close
of business on
Friday

EXECUTIVE OFFICE OF THE PRESIDENT

28-Jun-1996 05:11pm

TO: Carmena Parris

FROM: Jeffrey Levi
AIDS Policy Council

CC: Patsy Fleming
CC: Ursula Sanville

SUBJECT: printers

Next week, Sherry will be doing some major work on the National Strategy. She is going to need access to a printer -- is it possible to move my printer to the computer in Patricia's office so she can do things more efficiently? If that doesn't work, some other way to get her on line would be helpful. Thanks.

1stedict
6/13/96
"Prevention"
Section
SP

PREVENTION

The goal of prevention, as it pertains to the Nation's National HIV Strategy, is defined as reducing the number of new infections every year until there are no new infections. Prevention will require a clear definition of the different roles and responsibilities of the Federal government, and an on-going dialogue with the government's many partners in the public and private sectors about the responsibilities each has in developing effective prevention strategies.

We know that prevention works. We also know that the task of preventing HIV transmission in the United States as a means of controlling the epidemic of HIV and AIDS has reached enormous proportions.¹ 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 and, also, that approximately 40,000 to 60,000 Americans will become infected each year. Still, many more Americans who are not presently infected are at-risk of acquiring HIV.

HIV infection is a unique prevention challenge due to: the virus' virulence; the long period of time during which people may not be aware they are infected; the long duration of infectiousness; the near certainty of fatal prognosis; and, the potential for exponential spread. Moreover, HIV is transmitted primarily as a result of sex and drug use, each a personal and private individual behavior. To be effective, HIV prevention programs must reach tens of millions of Americans who are characterized by diversity of age, race, ethnicity, geographic locale, sexual orientation, and sexual and drug use behaviors.

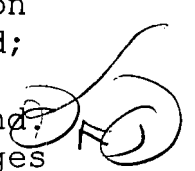
Prevention efforts are applied throughout a continuum of activities, from surveillance to research to social marketing initiatives, many of which are currently supported by several Federal agencies. (See Appendix A.) Most Federal prevention efforts are funded by the Department of

¹This section will address primary prevention activities. Other aspects of prevention, such as secondary prevention (i.e. preventing complications of HIV infection), development of topical microbicides, the behavioral components of vaccine research, and international prevention activities will be discussed in the following research, care and services, and international activities sections.

Health and Human Services (HHS), although other departments, such as the Department of Defense (DOD) and the Department of Veterans Affairs (VA), also support them.

Agency activities are reflective of their respective, agency-specific 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 sometimes focus on more 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) encourages broader access to prevention information through ^{both} the integration of prevention interventions into primary health care services and ^{slat} through its support of early intervention services for low-income medically underserved persons. Also, HRSA 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 the conduct of research performed at universities and private organizations, have been instrumental in expanding our HIV prevention knowledge base. However, significant gaps in information remain. We know from formal research and community experience that ^{that lets us know} developing effective prevention programs requires knowledge of: who is becoming infected; 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. 

Prioritizing prevention strategies must be guided and influenced by knowledge that improves our efforts to develop effective prevention programs, including, ^{knowledge that} ~~but not limited to, knowledge that~~: improves our understanding of the major modes of transmission; closes gaps in scientific 

intelligence, including identifying effective prevention models and strategies; and, eliminates gaps in program areas.

Opportunities for Progress

Modes of Transmission

*11-05
Hedley
am*
An important ^{aspect} ~~part~~ of strengthening prevention activities is ~~to have~~ a clearer understanding of who is being infected and the behaviors that are placing people at risk for infection. Recent epidemiologic data show that the HIV epidemic persists in the United States in consequence of: people who engage in injection drug use and their sexual partners; young and minority men having sex with men; heterosexual transmission, and 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. It is likely that many Americans, age 25 to 44, for whom HIV is the leading cause of death, became infected as 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.

11-05
A crucial aspect of effective prevention strategies includes supporting adequate surveillance of HIV infection and related diseases in order to gauge future directions of the epidemic, and to assess the effectiveness of prevention interventions. Seroprevalence surveys provide information on the level of HIV infections on selected "sentinel" populations. As the Federal agency with the primary responsibility for monitoring the epidemic, CDC's 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. Its surveillance system also provides essential data on HIV-related opportunistic infections. *✓*

There is room for refinement among the opportunities for

progress. While effective prevention intervention programs begin with sound information on who is at-risk, the current CDC surveillance systems neither currently captures sufficient "front-end" information on the incidence and prevalence of HIV (not AIDS) in the population, nor does it capture 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.) ~~CDC has~~ *However* recognized the value of this approach, ~~and~~ *CDC* has incorporated data collection design into its community planning process. These shifts in data needs also require that CDC reevaluate and reconfigure its data collection efforts; such a change may necessitate reconfiguring currently collected data to address these needs. As part of the agency's implementation of the recommendations set forth in the external review of CDC's HIV prevention strategies⁷, the CDC has initiated efforts to evaluate current data collection efforts and implement necessary changes, and the work should continue.

Prevention Research²

Factors that place individuals at risk for acquiring HIV infection involve a complex combination of behavioral, social, cognitive, and biological influences. Given this complexity, deciding which interventions will work must not be assumed intuitively, but instead based upon sound research findings and evaluation. Practical experience 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. There are three main areas of research, within which there are gaps about what is known, identified as: 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

² Information on NIH-supported behavioral and epidemiological research relevant to primary prevention can be found in Appendix B: Research.

foundation for prevention programs. Basic behavioral research, similar to basic research in other areas of scientific inquiry, seeks to explain the 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 influence HIV by reducing the number of new infections.⁸ 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 needed. Such data enable scientists to establish theories of behavioral change, which then provide researchers with tools for identifying the most appropriate and effective approaches for an individual or a community.⁹ [Awaiting revised language from NIH.]

Intervention Research. A second major area in research where there are gaps in what we know about HIV, is the area of prevention interventions, i.e., research that concentrates on modifying behaviors, such as those related to drug use and sexual practices. In HIV and AIDS, intervention research can focus on both individuals and communities, which often hold norms that influence personal behavior. 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 determine and advance approaches to reducing unhealthy behaviors.

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.¹⁰ Studies have shown that community-based HIV risk reduction programs that are gender relevant and culturally sensitive can be effective.¹¹ 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.¹²

Despite 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 of research that influences reductions in HIV at-risk behavior, is research on the effectiveness of treatment for drug abuse, mental illness, and alcoholism.

Agencies that support intervention and behavioral research must include scientists from a broad range of disciplines in their planning activities. Also, they will need to improve their data-sharing and collaborative efforts with other agencies responsible for implementing prevention programs. Enhancing the dialogue between researchers in related disciplines will invariably improve the development of effective prevention interventions.

Social Marketing Research. It is important to incorporate the findings from basic behavioral and intervention research 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 innovative nature of such an endeavor, 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 the community-based organizations developing prevention programs that confront the epidemic. Moreover, these CBO's often do not, or are not able to, take advantage of current information 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. Currently, the Federal government supports a range of programs that address the disparate needs of a number of at-risk populations. Shifting demographics of the epidemic, coupled with restricted resources, however, has resulted in gaps in particular program areas that limit the Nation's ability to prevent new infections. It is important, therefore, that prevention planners carefully prioritize their efforts based on local epidemiology.

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

One of the most important innovations in the area of prevention is community planning. The community planning process is, itself, a model of a Federal-local partnership. Through joint effort, it is possible to establish combined goals for the prevention of HIV that meet Federal standards while remaining responsive to local needs. Community planning is in early stages of development, and still requires significant, on-going leadership and technical assistance from CDC to fulfill its potential for influencing decision making and setting effective priorities.

Substance Abuse Prevention and Treatment. Injection drug use

is one of the major forces driving the HIV epidemic; one third of all new cases are directly or indirectly related to this mode of transmission. Limiting the impact of injection drug use on the epidemic will require: improving the integration of HIV prevention activities and substance abuse treatment and prevention programs since the epidemics of each are interrelated and overlapping; increasing treatment services for people trying to control their addictions; and, increasing the enrollment of drug users in existing drug treatment and service programs.

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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 x percent of the population is affected by alcohol abuse and other non-injectable drugs. An aspect of the Federal response to this problem should include an increase in the availability of treatment for a range of alcohol and drug addictions.

Fundamental to the success of the integrated approach are the continued expansion of intervening educational activities that influence prevention of substance abuse and increased outreach efforts that encourage active substance users to seek treatment. Again, it is necessary to ensure that drug treatment services are available in sufficient numbers for those in need of such services; in particular, services that accept pregnant women or women with children, indigent members of the community and adolescents.

Work on integrating HIV and substance abuse prevention activities and programs has already begun. CDC convened a meeting of state and local people involved in both public health and drug prevention to develop an action plan that integrates HIV prevention and substance abuse prevention. This meeting was an important initial step highlighting the need for continued dialogue among various groups (i.e., public health officials, law enforcement, community representatives, clinicians, etc.) to address the issues related to preventing HIV transmission among drug users.

Treatment for Tuberculosis and Sexually Transmitted Diseases. HIV-infected people are at very high risk of

developing TB disease. For example, people infected with both *M. tuberculosis* (*Microbacterium tuberculosis*) and HIV are more likely to develop TB disease than people who are infected only with *M. tuberculosis*. Studies suggest that the risk of developing TB disease is 7 to 10 percent each year for persons infected with both TB and HIV, as opposed to the risk for persons not infected with HIV, which is 10 percent over an entire lifetime.¹³ In addition to many other health implications for HIV/TB infected people (those infected with TB disease), there is also an increased risk of transmission of TB to household members, health care workers, and other persons having regular contact with the person with TB disease.

Further, there is the strong, twofold evidence that the HIV epidemic has contributed to the increase in the number of TB cases: first, the geographic areas that have been most affected by the HIV epidemic have also reported the largest increases in TB cases; second, from 1985 to 1992, the largest increase in TB cases occurred among people aged 25 to 44, the age group most affected by AIDS.¹⁴

Studies have shown that the presence of sexually transmitted diseases (STDs) can significantly increase the efficiency of HIV transmission, in some instances, 20 fold. 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.^{15, 16} 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.

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. Reaching prevention goals will require improving the integration of prevention messages and activities 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 people seeking HIV testing can have access to the necessary services, CDC should institute counseling practices and testing guidelines that acknowledge and address the needs of individuals seeking the services and provide the respective training to personnel at CDC-funded sites.

CDC guidelines should advise incorporation of 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. More specifically, guidelines should also offer pregnant women information about, and access to, AZT during pregnancy to reduce the risk of perinatal transmission. Finally, training should be made available to improve primary care providers' skill, comfort level and sensitivity in these areas.

Achieving an adequate 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.

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. Effectiveness measures must become a standard component of all Federally-funded programs. Whether our efforts have been effective in slowing the epidemic will be determined by: (1) sound evaluation practices; (2) careful examination of what programs should be continued; (3) determination of which activities need initiation; and, (4) an awareness that a reconfiguration of certain program priorities may become necessary.

The Public Health Service Agencies within DHHS with responsibility for a range of activities and programs associated with the HIV epidemic are: the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMSHA), the Health Resources and Services Administration (HRSA), the Agency for Health Care Policy and Research (AHCPR), the Food and Drug Administration (FDA), and the Indian Health Service (IHS). Information regarding these agencies can be found in the Appendices.

2 Public Health Service Plan for the Prevention and Control of Acquired Immune Deficiency Syndrome (AIDS), Public Health Reports 100:453-455, September-October, 1985.

Coolfont Report. A PHS plan for the Prevention and Control of AIDS and the AIDS Virus. Public Health Reports 101:341-348, July-August 1986.

Report of the Second Public Health Service AIDS Prevention and Control Conference. Public Health Reports. Vol. 103 Supplement No.1 (Revised). 1988.

The Public Health Service Strategic Plan to Combat HIV & AIDS in the United States. U.S. Department of Health and Human Services. 1992.

AIDS: An Expanding Tragedy. The Final Report of the National Commission on AIDS. Washington, DC. 1993.

7 External Review of HIV Prevention Strategies by the CDC Advisory Committee on the Prevention of HIV Infection. U.S. Department of Health and Human Services, Public Health Service. June 1994.

8 *AIDS and Behavior: An Integrated Approach*. Judith D. Auerbach, Christina Wypijewska, and H. Keith H. Brodie, Editors. Institute of Medicine, National Academy Press, Washington, D.C., 1994. p.79.

9 *AIDS and Behavior: An Integrated Approach*. Judith D. Auerbach, Christian Wypijewska, and H. Keith H. Brodie, Editors. Institute of Medicine. National Academy Press. Washington, DC. 1994.

10 AIDS and Behavior: An Integrated Approach

11 JAMA article used in PRIM&R speech

12 Don C. Des Jarlais, Holly Hagan, Samuel R. Friedman, Patricia Friedmann, David Goldberg, Martin Frischer, Steven Green, Kerstin Tunving, Bengt Ljungberg, Alex Wodak, Michael Ross, David Purchase, Margaret E. Millson, Ted Myers. Maintaining Low HIV Seroprevalence in Populations of Injecting Drug Users. JAMA, October 18, 1995 -- Vol. 274, No. 15. pp 1226-1231.

13 Transmission and Pathogenesis of Tuberculosis, Self-Study Module on Tuberculosis, Module Number 1, Division of Tuberculosis, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention (CDC), p.20.

14 ¶Epidemiology of Tuberculosis,¶ Self-Study Module on Tuberculosis, Module Number 2, Division of Tuberculosis, National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention (CDC), p.15.

15 Heiner Grosskurth, Frankc Mosha, James Todd, Extra Mwijarubi, Arnould Clokke, Kesheni Senkoro, Philippe Mayaud, John Changalucha, Angus Nicoll, Gina ka-Gina, James Newell, Kokuugonza Mugeye, David Mabey, Richard Hayes. Impact of Improved Treatment of Sexually Transmitted Diseases on HIV Infection in Rural Tanzania: Randomized Controlled Trial. The Lancet, Vol. 346, August 26, 1995.

16 Maria Wawer, Science. 9.08.95, vol. 269, No. 5229

17 Alan B. Stone, and Penelope J. Hitchcock. Vaginal Microbicides for Preventing the Transmission of HIV. AIDS 1994, 8 (suppl 1):S285-S293.

18 Housing and the HIV/AIDS Epidemic: Recommendations for Action. National Commission on AIDS. Washington, D.C. July 1992.

19 HIV/AIDS Policy Guidance. U.S. Agency for International Development. September 1995.

20 Douglas S. Paauw, Marjorie D. Wenrich, J. Randall Curtis, Jan D. Carline, Paul G. Ramsey. Ability of Primary Care Physicians to Recognize Physical Finding Associated with HIV Infection. JAMA. 1995; 274:1380-1382.

21 Colombotos, J., Messeri, P., McConnell, M.B., et al: Physicians, Nurses, and AIDS: Findings From a National Study. Rockville, MD: Agency for Health Care Policy and Research; 1995. Grant No. HS06359. (NTIS Publication PB95-129185)

Jane: 6/5/92 7:45 a.m.

I don't think I understand this document's purpose or how, and by whom, it is to be used.

The verbatim repetition is so glaring that there must be something I don't know. I asked Jeff, he

June 17, 1:05 pm
Jane: —

Here is the rest of the "substantive text," edited (unedited).

Sherry

Told me to talk to you. I have an appointment this a.m. at 11:00 (will leave at 10:15-ish). I decided to come in until just before that time to continue working on document and to talk about it.

I thought I was taking home an edit job — This is a lot more than that unless I'm missing pertinent information. Please advise.

Sherry

When is it appropriate to write/say HIV/AIDS, or HIV/AIDS?
Question applies to entire text of the National Strategy document.

6/17/96
1 pm
sd

INTERNATIONAL ACTIVITIES *is this redundant?*

AIDS is a global pandemic. In the United States, it is estimated that between 800,000 and 1 million people are currently infected with HIV. The World Health Organization (WHO) estimates that 18.5 million adults and over 1.5 million children are currently infected worldwide and there will be 10 to 15 million orphans worldwide attributable to HIV/AIDS by the year 2000. WHO also estimates that two to three million new HIV infections can be expected annually, and by the year 2000, thirty to forty million people will have been infected around the globe.

The pandemic jeopardizes decades of economic and social in many developing nations. In Africa and Asia, economic advances are threatened, and in some cases, may be reversed due to the pandemic of HIV and AIDS. Socio-economic studies have shown a decrease in overall domestic savings and investment levels, negative effects on foreign investments, reductions in the volumes of imports and exports, and a reduction in receipts from tourism.¹⁹ In many countries, governments will be forced to cope with increasing numbers of cases, weakened health care systems, a deleterious economic impact on the most productive segments of society, and the reduction in the number of healthy men and women able to serve in the government and the military. *what? ward? missing here? achieved? maybe?* *only in govt & military*

Due to the global nature of the ~~pandemic~~ *epidemic*, its negative impact on both developed and developing countries cannot be overstated. It is clear that if we do not stop the pandemic ~~globally~~, we will not be able to halt its spread in the United States.

At present, several Federal agencies are working at slowing the AIDS epidemic internationally. (See Appendix D.) The Department of State has worked with other departments, agencies, and non-governmental organizations to develop a framework to guide U.S. foreign policy in the global efforts against HIV and AIDS. The major areas identified for U.S. leadership are: preventing new infections; reducing the personal and social impact of the pandemic; and mobilizing and unifying national and international efforts. The U.S. Agency for International Development (USAID) also has a leadership role in the global HIV effort through development assistance, research and policy formation. USAID focuses

HIV/AIDS
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its strategy on developing prevention programs based on ^{that are} proven interventions; addressing social, cultural, regulatory and economic issues related to HIV/AIDS and other sexually transmitted infections; and, developing and testing new interventions and methods to prevent transmission and mitigate the impact of the epidemic. The U.S. Information Agency (USIA) supports programs that promote dissemination of U.S. policies and information related to HIV and AIDS ²⁰ and ~~The~~ Peace Corps trains a portion of its volunteers to directly address HIV-related concerns in their countries of placement. ~~In~~ ^{also} addition, several agencies support research overseas, including the National Institutes of Health, the Centers for Disease Control and Prevention, and the Department of Defense (DOD). The DOD is conducting clinical trials of candidate HIV vaccines in Thailand and NIH, (working in collaboration with USAID), supports basic scientific studies on social and behavioral aspects of AIDS in developing countries. ^{an example of what CDC is doing abroad. - why} ~~[Awaiting additional language from NIH.]~~ ^{trials and} The results of the studies ultimately will be used to develop interventions to reduce behaviors that place individuals at risk for contracting HIV infection.

Opportunities for Progress

International Leadership. The United States has established a ~~global~~ leadership role in combating the ~~epidemic~~ ^{pandemic}. This leadership must continue. The U.S. strongly supports the newly established Joint and Co-sponsored United Nations Programme on AIDS (UNAIDS); ⁴ Moreover, the U.S. is a member of the governing body of UNAIDS.

The U.S. also supports efforts to more effectively make use of available resources as well as to encourage non-traditional donor countries to provide much needed contributions. Supporting UNAIDS and its innovative programmatic efforts, ^{including} and its goal of working to increase the availability of therapeutics (and vaccines when

⁴ Until recently, the United Nation's response to HIV/AIDS was carried out primarily by the World Health Organization's Global Programme on AIDS. On January 1, 1996 the U.N. launched UNAIDS, co-sponsored by six U.N. agencies to strengthen coordination and focus support for HIV/AIDS activities at the global and country levels. UNAIDS has established three mutually reinforcing roles: to be a major source of policy development and research; provide technical support; and be an advocate for comprehensive, multi sectoral responses to the pandemic.

developed) to the residents of developing countries, is not only morally correct, but also furthers U.S. interests by promoting economic and social stability worldwide.

Sharing Technology and Bringing Lessons Home. (Include footnote to this project for those who are not familiar with its content). In addition to financing the development of large scale, comprehensive AIDS prevention programs in many countries, USAID has gained valuable insights and lessons from experiences from these countries and is applying them to U.S. populations. Based on the Vice President's initiative to bring the lessons back home through the "Lesson without Borders Project" to inner city and rural areas with problems similar to those experienced overseas, the goal is to create linkages between U.S. community organizations and international projects in order to share solutions to problems that know no borders. The U.S., through its various agencies, will continue to build and strengthen networks that will facilitate leadership, coordination and transnational approaches to AIDS prevention and control programs and AIDS related research; to exchange culturally and linguistically appropriate educational and training materials; and to demonstrate the bidirectionality of USAID international programs and its potential impact on US based programs, U.S. based non-governmental organizations and indigenous groups.

Program Coordination. One of the most challenging aspects of the U.S. effort is effective coordination among a host of agencies with varied missions and activities. The State Department and agencies such as USAID and USIA are primarily focused on country-specific activities that include many HIV-related objectives. Other agencies, such as NIH and CDC, also support international activities. [Awaiting additional language from NIH.]

These differences in focus present challenges in effectively planning, coordinating, and evaluating the overall U.S. international effort. Therefore, in order to improve this endeavor, the agencies supporting international activities must develop a mechanism for identifying and coordinating their efforts.

state-of-the-art
what?

The Federal government must develop a mechanism for ensuring periodic assessment of the state-of-the-art, ensuring that essential information can be found easily, and disseminating that information widely. ^{all of which} This will require collaboration ^{ed} between and among ^{ed} industry, government, and professional groups.

Coordination of Federal Activities. Enhancing coordination of information dissemination activities among Public Health Service agencies is an important priority. Within the DHHS, the Office of HIV/AIDS Policy has the lead responsibility for coordinating the HIV-related activities of the Public Health Service. ~~Ensuring that information about a research breakthrough is easily available to the appropriate persons and organizations, and that policies and standard-of-care practices for Federally-sponsored programs are modified to reflect the new standard, will require for continuing~~ continued high level of cooperation and coordination among Public Health Service agencies. ~~(awaiting revised language from HHS)~~

~~With an improvement in~~ improved information dissemination efforts are also needed in the area of primary prevention models. ~~As noted in the~~ ^{as noted in the prevention section} prevention section, ^{where} good models of effective prevention interventions have been developed, ~~but~~ often this valuable information is not reaching those persons developing, implementing, and evaluating prevention programs. Here again, the Public Health Service must take the lead in ensuring that information which can be used to stem the tide of new infections reaches those who can make a difference.

what
another
indirect
attack
CDC
etc.!!

check

A continuing high level of cooperation and coordination among Public Health Service Agencies will ensure that information about a research breakthrough is easily available; it reaches the appropriate persons and organizations; and, policies and standard-of-care practices for Federally-sponsored programs are modified to reflect the new standard.

TRANSLATION OF RESEARCH INTO PRACTICE

An important element in our fight against AIDS is ensuring that hard won research advances are translated into practice (i.e., ensuring that new knowledge is incorporated into standard medical practice of clinicians caring for persons living with HIV). The increasing presence of HIV in every community necessitates that all health care providers become knowledgeable about assessing risk, promoting prevention, and caring for persons with HIV.

Improving the translation of research advances into daily clinical practice will require an ongoing collaborative effort on the part of the Federal government, individual health care providers, medical schools, professional organizations, international organizations, health centers and hospitals, and other ~~parts~~ ^{members} of the private sector.

Information dissemination activities fall ~~under~~ ^{within} the missions of several agencies. (See Appendix E.) The National Institutes of Health (NIH) supports a broad range of efforts including a "Clinical Alerts" mechanism for the dissemination of clinical trials results to health professionals, the media, and the general public. DHHS supports and directs the International HIV/AIDS Clinical Conference Call series which disseminates critical, state-of-the-art clinical care information to primary care providers via live world-side audio tele-conferencing. NIH also supports publicly available computerized databases such as AIDSDRUGS, AIDSTRIALS, and AIDSLINE. In addition, the toll-free 1-800 TRIALS-A AIDS Clinical Trials Information Service (ACTIS) is co-sponsored by NIH, CDC, and FDA.

[Awaiting additional language from NIH.] The Centers for Disease Control and Prevention (CDC) disseminates information through hotlines such as its toll-free 1-800-HIV-0440 HIV/AIDS Treatment Information Service (ATIS) and the AIDS Information Clearinghouse.

The CDC ~~also~~ issues guidelines for health professionals through its ~~Morbidity and Mortality Weekly Report~~ ^{members}; such guidelines have included ~~The~~ ^{The} U.S. Public Health Service Recommendations for HIV Counseling and Voluntary Testing for Pregnant Women. The Agency for Health Care Policy and Research (AHCPR) has published a series of HIV-related clinical practice guidelines for clinicians and companion

pamphlets for their patients; an example these materials are clinician guidelines for the evaluation and management of early HIV infection. ~~The Health Resources and Services Administration~~ ^{HRSA} also developed guidelines for its CARE Act grantees; funds an AIDS warmline which responds to questions from clinicians across the country; and directs a nationwide system of AIDS Education and Training Centers which provide state-of-the-art HIV clinical information to health care providers.

Opportunities for Progress

Due in part to Federally-sponsored information dissemination activities, dramatic changes in the way HIV is treated have taken place over the last 15 years. However, despite these ^{success} successes, there are still areas ^{needing} for improvement.

For example, an AHCPR-supported study indicated that primary care physicians may miss significant HIV-related symptoms during patient examinations.²⁰ Other research indicates that a disturbing number of clinicians do not use universal precautions in the course of routine patient care.²¹ ^{didn't say they were "successes," just dramatic changes.} ^{universal precautions which are 23%?}

We are also at a stage, unlike in the beginning of the epidemic, where research advances are coming more frequently. In the case of the NIH study which demonstrated it is possible to block perinatal transmission by administering a specific AZT regimen to the mother and baby, it became clear that ^{that} ~~this~~ ^{scientific breakthrough} ^{would} require a change in the standard-of-care. ^{that} ~~this~~ ^{change} also required the development of new testing and counseling guidelines to reflect the new options available to women. ^{And} ~~it~~ meant, that for patients enrolled in Medicaid and Medicare to receive access to ^{the regimen} ~~this breakthrough~~, a policy change on the part of the Health Care Financing Administration (HCFA) was required. ^{choice of word} ^{that} ^{the regimen} ^{royalist!}

State-of-the-Art Guidelines. One of the most difficult tasks for clinicians and patients is interpreting the ^{patchwork} ~~patchwork~~ of data and articles regarding treatments and converting ^{it} ~~it~~ into a therapeutic strategy. With every research breakthrough, ^{the} ~~this~~ task becomes more difficult. ^[Awaiting additional language from NIH.] ~~It is~~ essential that practical information for practicing clinicians and their patients is provided in a timely manner. ^{Step} ^{the plugs are offering you nothing.}

CIVIL RIGHTS

One of the Nation's common goals is to ensure that treatment of persons living with HIV is caring, ethical, and in accordance with legal standards. Discrimination based on HIV status ~~is~~ is illegal and morally wrong.

Discrimination undermines the Nation's efforts to prevent and treat HIV infection and bring the epidemic under control. ^{Due to} (Because) of fear of discrimination and stigma, ~~many~~ ^{many} people do not voluntarily seek testing for HIV, ~~remain~~ ^{remain} unaware of their HIV status, ^{and education} consequently do not take advantage of care that could help them live longer, healthier lives. ~~In addition, opportunities to educate people are lost.~~ ^{It is also} discrimination can ~~also~~ ^{also} wrongfully deny persons ^{HIV infected} access to housing, employment, and health care. ^{individuals}

The Federal government and some States have enacted laws that protect persons with HIV from discrimination on the basis of their infection. Many of the more common legal issues faced by people living with HIV and AIDS, such as family law issues, estate planning, landlord/tenant problems are regulated by State law.

The primary source of Federal statutory protection for people living with HIV is the Americans with Disabilities Act of 1990 (ADA). (Federal agencies are prohibited from discriminating against people with disabilities under the Rehabilitation Act of 1973.) Title I of the ADA prohibits discrimination against qualified disabled individuals in employment settings. The Equal Employment Opportunity Commission (EEOC) is responsible for enforcing Title I. Title II of the ADA prohibits discrimination on the basis of disability with regard to public services, while Title III prohibits discrimination on the basis of disability in public accommodations. The Department of Justice (DOJ) is responsible for enforcing Titles II and III. The Health Care Financing Administration (HCFA) also enforces regulations regarding the treatment of HIV-infected persons.

Opportunities for Progress

Enforcement of Federal Laws. The Federal government has aggressively and successfully prosecuted private sector violations of the ADA. These efforts will continue. Under

who?
AIDS

this provision, the government has been extremely successful in prosecuting a range of cases, including clinicians who have refused to care for HIV infected patients and employers who have dismissed persons based on their actual or perceived HIV status. In addition to ongoing efforts, a joint Department of Justice and Health and Human Services program will seek to combat nursing home discrimination against persons living with AIDS.

Federal Policies. The Federal government must also actively work to remedy any of its own existing discriminatory policies. The Director of the Office of National AIDS Policy is working with Federal agencies to ensure that HIV testing programs follow the recommendations of public health professionals. The Administration will also continue to oppose Congressional attempts to force discharge of infected military personnel who are still able to serve their country.

Leadership. The United States has made progress in fighting discrimination. However, the enactment of laws is insufficient to end discrimination. As a Nation, we need to be vigilant and vocal in our efforts to fight discrimination. This is a responsibility that must be shared among Federal agencies, states, communities, and the citizens of this country.

6/6

Sherry-

On the third page is ^{the} Revised section for the 'international text' that was Really Rough in the version you have.

Let's touch base before you go today. Leave me the disc with your changes and I can cross-walk it tomorrow.

Thanks!
Jane

The Evolving Challenge of the HIV/AIDS Epidemic

The four decades prior to the report of the first AIDS case in the early 1980s were a period of unprecedented success in controlling infectious diseases. The emergence of HIV, and the subsequent epidemic of HIV and AIDS, has posed an evolving series of unique scientific, economic, and social challenges both domestically and internationally. Moreover, the challenges we face today with the epidemic are very different than challenges

we faced ten or even five years ago.

In the early years of the epidemic, significant scientific resources were dedicated towards understanding how the disease was transmitted and identifying its underlying cause. Thanks to this work, we now know the risk factors, the etiologic agent, and we have a test to ascertain the serostatus of infected persons and protect the blood supply.

Building on the knowledge gained from those discoveries, more resources were subsequently directed towards achieving a deeper understanding of HIV-related immunology and pathogenesis, and, developing therapies for the primary infection and associated opportunistic infections. New and more powerful therapies that offer new hope for treatment and prevention have been developed. Scientists now believe that a vaccine is possible. The discoveries of today also create the challenges for the future. We now face new scientific challenges in developing a vaccine and the new generation of therapeutics for primary infection and opportunistic infections.

Since the beginning of the epidemic, behavioral research designed to understand the behavioral, social, cognitive, and biological factors that place individuals at risk for acquiring HIV infection has provided insights. Practical experience has also taught us that prevention efforts can be effective. However, behavioral research remains a relatively young science and there are currently more questions than answers. The challenge before us now lies in expanding the scientific underpinnings that will allow us to design more effective prevention programs that will reach even more Americans at risk for infection.

The progress in developing therapies and prevention programs has also spawned new problems for the health care delivery system. As a result of improved therapies, people with AIDS now live twice as long as they did a decade ago. [Awaiting additional language from NIH.] Due to NIH-sponsored research we now have the ability to reduce the risk of perinatally acquired HIV infection by treating women with AZT during pregnancy. The recent approval of a new class of therapies, protease inhibitors, will again change the direction of HIV/AIDS treatment and prevention. The challenge facing us now is to ensure access to these therapies. We need to improve our efforts in providing people with care early in their infection so they can receive the new treatments and training health care professionals so they know the best way to provide that care.

Ensuring access to prevention services and medical care for the growing number of people who need or will need health care is an enormous task. There are societal and economic changes that are influencing the ways the country addresses the issues of health care access and cost. There is a trend towards decentralizing

the role of the Federal government in health care and placing more responsibility at the state and local levels coupled with a movement to managed care systems. These changes will influence efforts to strengthen prevention efforts and ensure health care and services for persons with HIV/AIDS.

However, despite advances in research and care HIV infection continues to spread, further emphasizing the importance of improving primary prevention and access to state-of-the-art therapies. More women are becoming infected. Youth are at increasing and special risk -- AIDS is now the leading cause of the death for persons aged 25 to 44, and it is likely these persons were infected during adolescence. Racial and ethnic minorities are disproportionately represented among existing and new cases of HIV infection. The geographic diversity of the disease has widened, thereby increasing the impact on the country as a whole.

Internationally, the spread of HIV threatens to undermine the economic progress and political stability of many developing nations. In the early years of the epidemic, the Special Programme on AIDS, which later became the Global Programme on AIDS, was set up at a time of global fear and uncertainty. There was a great deal of uncertainty and hope that the HIV outbreak could be brought quickly under control through a vaccine. There were many questions, including -- what were the best way of preventing new infections and would HIV spread to all parts of the world or would some countries be spared?

Today, as the Joint United Nations Programme on HIV/AIDS is born, time has answered many of these questions. Of all the lessons that we have learned, the biggest one is that there is no quick or simple solution to the AIDS epidemic, medical or otherwise. We have moved beyond the medical model and one bullet approach to solving the worldwide pandemic. It is in this context that we need to focus on broader, socioeconomic factors such as poverty and access to health services.

And finally, from a societal perspective, we have made tremendous progress but still have a long way to go in overcoming fear and discrimination. There are no grounds for discriminating against persons with HIV infection because of fears they pose a risk in the workplace or housing. Discrimination has thwarted access to health care, health insurance, housing, employment, and even funeral services. However, progress has been made in ensuring that the protections provided under the law are extended to all HIV-infected persons. The challenge before us today is to be vigilant in our efforts.

6.5.96, 11:50 am

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.¹ 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

¹ This section will address primary prevention activities. Other aspects of prevention, such as secondary prevention (i.e. preventing complications of HIV infection), development of topical microbicides, the behavioral components of vaccine research, and international prevention activities will be discussed in the following research, care and services, and international activities sections.

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 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 on selected "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 currently 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 also require that the CDC reevaluate and reconfigure its data collection efforts; such a change may necessitate reconfiguring currently collected data to address these needs. As part of the agency's implementation of the recommendations set forth in the external review of CDC's HIV prevention strategies¹², the CDC has initiated efforts to evaluate current data collection efforts and implement necessary changes, and this work should continue.

Prevention Research²

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

² Information on NIH-supported behavioral and epidemiological research relevant to primary prevention can be found in Appendix B: Research.

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.¹³ 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.¹⁴ [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.¹⁵ Studies have shown that community-based HIV risk reduction programs that are gender relevant and culturally sensitive can be effective.¹⁶ 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.¹⁷

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 disciplines 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 so we must continue to work to integrate HIV prevention into current substance abuse programs and integrate substance abuse prevention into HIV prevention.

Another major avenue for controlling the spread of HIV among addicted persons is to enroll them in drug treatment programs. Substance abuse treatment is a form of HIV prevention. At present, there is a continuing need for increased treatment services for persons seeking to control their addictions.

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 x percent of the population is affected by alcohol abuse and other non-injectable drugs. Part of the Federal response to this problem should be increased the availability of treatment for a range of alcohol and drug addictions.

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 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 convened a meeting of state and local people involved in both public health and drug prevention to develop an action plan that integrates HIV prevention and substance abuse prevention. This meeting was an important initial step and highlighted the need for continued dialogue among various groups (i.e., public health officials, law enforcement, community representatives, clinicians, etc.) to address the issues related to preventing HIV transmission among drug users.

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.^{18, 19} 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.²⁰ 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.

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.