

CDUHR news

Center for Drug Use and HIV Research

in the Institute for AIDS Research at National Development and Research Institutes, Inc.

Globally, approximately 5% of HIV infections in adults are directly related to injecting. However, in some areas of Eastern Europe and Asia, drug injection accounts for 50-90% of HIV infections.

HIV/AIDS and Injection Drug Use Epidemics: International Trends

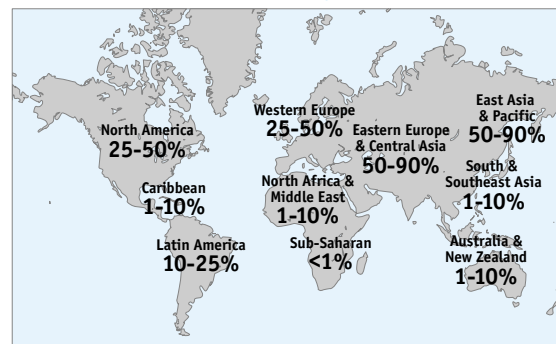
In July 2002, the 14th International AIDS Conference is being held in Barcelona, where updates on the HIV/AIDS epidemic will be presented from around the world. Many CDUHR investigators will be presenting findings and the Center has increasingly become involved in conducting research in international locales. This article will summarize global trends with an emphasis on the joint HIV/AIDS-injection drug use epidemic.

By the end of 2001, UNAIDS estimates that over 40 million people in the world were living with HIV. HIV/AIDS is the fourth leading cause of death in the world and is the leading cause of death in sub-Saharan Africa. By far, sub-Saharan Africa has been the most severely affected region with over 28 million people infected.¹ Globally, the primary mode of transmission is through sexual contact. However, in many local, national and regional epidemics, injection drug use (IDU) plays a major role in the spread of HIV.

REGIONAL OVERVIEWS

Evidence suggests that the HIV-drug use epidemic is continuing to expand. In 1992, 80 countries documented cases of drug injection; of these, 52 reported HIV infection associated with injection drug use. By 1999, 114 (of 134 countries documenting drug injection) reported HIV infection in IDUs. Globally, approximately 5% of HIV infections in adults are directly related to injecting, but there is considerable regional variation. In Eastern Europe, Central Asia, Eastern Asia and the Pacific region, 50-90% of HIV infections are from drug injection; in North America and Western Europe, 25-50%; in Latin America, 10-25%; in North Africa, the Middle East, South and Southeast Asia and Australia and New Zealand, 1-10%; and in sub-Saharan Africa, less than 1%.² The following are regional overviews of HIV/AIDS epidemics.

Proportion of Adults Living with HIV/AIDS Who Acquired HIV through Injection Drug Use



Globally: approximately 5%

Source: Needle, et al., 2000.²

Eastern Europe, Central Asia and Central Europe

HIV infections are increasing faster in Eastern Europe than any other region in the world.¹ The epidemic started in the early 1990s after the fall of Communism. With the ensuing economic and political changes, IDU has increased, along with other HIV risk behaviors.³ In the Russian Federation, newly reported diagnoses have been doubling annually since 1998. Belarus, Moldova and Ukraine have also seen rapid increases in HIV infection. The epidemic is mainly concentrated among IDUs and is thought to be much higher than the reported rates.¹ The situation is likely to worsen due to the large numbers of IDUs in the region, high rates of needle sharing and syphilis, and other social and economic factors.⁴ In Central Asian countries (Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan) outbreaks of HIV, related to IDU, have been reported.^{1,4} In Central Europe, HIV prevalence remains low in countries such as the Czech Republic and Hungary, where national HIV programs are in operation.¹

Asia and the Pacific

This region is the most populous in the world, so even relatively low prevalence rates can translate into large epidemics. In China, health officials estimate that 850,000 Chinese are living with HIV and needle sharing accounts for 68% of the infections.⁵ There are HIV prevalence rates higher than 70% among IDUs in provinces (Continued next page.)

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such as Yunnan and Xinjiang. An additional nine provinces may be on the brink of epidemics among IDUs because of high rates of needle sharing.¹ In India, where the adult prevalence rate is at 1%, HIV prevalence among IDUs, in Manipur, is over 50%. There is also evidence of high rates among IDUs in Delhi (44.5%) and Imphal (over 80%).⁶ In Indonesia, after a decade of low HIV rates, by 1999/2000, 15% of IDUs were infected, and by 2001, 40% of injectors in drug treatment in Jakarta were infected; in Bogor, 25% of IDUs tested positive for HIV; and in Bali, there was a 53% prevalence rate among incarcerated drug users.¹ In Vietnam, approximately 20% of IDUs (data aggregated across the country) are living with HIV. However, in several provinces, the rates are well over 50%. Initially, prevalence was highest among the southern provinces, but there have been increases in the northern provinces and currently it appears that the highest rates are in the central region of the country.⁷ Prevention programs have reduced new HIV infections among pregnant women in Cambodia. In Thailand, prevention measures have reduced new HIV infections to about 30,000 from 140,000 annually, a decade ago. However, the ongoing high prevalence and incidence rate among IDUs continues.¹

North Africa and the Middle East

The factors and risk groups driving the epidemic have not been systematically studied in the coun-

tries in this region. However, evidence suggests that the predominant mode of transmission is through sexual contact. HIV prevalence rates are rising among tuberculosis patients in Sudan (8%), Oman (4.8%), Iran (4.2%) and Pakistan (2.1%). All countries in the region (except Sudan and the Republic of Yemen) have reported HIV transmission related to drug injecting.¹

Sub-Saharan Africa

The HIV epidemic is predominantly driven by heterosexual transmission in this region. In the early 1980s, Uganda, Kenya and Tanzania were among the first countries where the AIDS epidemic was recognized. There is at least 10% HIV prevalence in 15-49 year olds in 16 countries, including seven in southern and Eastern Africa, where there are prevalence rates over 20%. In Botswana, 36% of the adult population is infected with HIV.⁸ Injection drug use has been reported in several sub-Saharan African countries including Nigeria, Kenya, Ghana and South Africa.⁹ However, the relationship between drug use and HIV has generally not been well studied in this region. In two small studies conducted in South Africa, drug use was associated with a lower risk for HIV among arrestees,¹⁰ and among sex workers HIV prevalence was lower among drug users.¹¹ A third study conducted in South Africa indicated that men who use alcohol were three times as likely to be infected with HIV.¹²

INFORMATION ON GLOBAL HIV/AIDS TRENDS

These Web sites are a sample of the information available on the internet related to the HIV/AIDS-drug use epidemic.

Joint United Nations Programme on HIV/AIDS (UNAIDS)

<http://www.unaids.org>

Surveillance of HIV/AIDS at the international level. Information is organized by country and subject. Reports are available online and can be downloaded.

United Nations Office for Drug Control and Crime Prevention (ODCCP)

<http://www.odccp.org>

Provides information on international illicit drug use patterns and distribution.

Journal of the American Medical Association (JAMA) International Resources

<http://www.ama-assn.org/special/hiv/bestonet/global.htm>

Links to sites in different countries which include information on HIV prevalence, treatment, training, community-based organizations and other resources.

International Harm Reduction Association (IHRA)

<http://www.ihra.net>

Links to drug policy and other harm reduction organizations. IHRA encourages dialogue about drug policies and public health outcomes.

Targeted prevention and intervention programs have averted and even reversed HIV epidemics among IDUs. In order to develop timely, effective programs, updated data on the populations at greatest risk for becoming infected are essential.

North America and Western Europe

Since the advent of highly active antiretroviral therapies (HAART), deaths attributed to HIV have declined in these regions. Wider access to HAART treatment may be leading to increased sexual risk behavior (evidenced by increased rates of gonorrhea and syphilis among MSM in some regions) due to the misperception that these treatments are a cure for HIV.¹ In the U.S., IDU accounts for over 30% of the AIDS cases,¹³ while men who have sex with men (MSM) continues to account for the largest proportion of new infections (53%).¹ Increasingly, African-Americans and Latinos are disproportionately infected with HIV.¹ New York City (which had the largest IDU-related HIV epidemic in the world) has continued to show declines in prevalence among IDUs.¹⁴ In Canada, Germany, Greece and the United Kingdom new HIV infections and other sexually transmitted infections among MSM have increased.¹ Overall, in Western Europe, newly diagnosed HIV infections among IDUs have declined, except in Portugal where new infections have been increasing since the mid 1990s.¹⁵

Latin America and the Caribbean

In Central America and the Caribbean, HIV is transmitted mainly through heterosexual sex. The Caribbean has the second highest adult HIV prevalence rate (2.2%) in the world, and in Haiti and the Bahamas the rates are approximately 4%. Barbados, the Dominican Republic, Belize, Guyana, Honduras, Panama and Suriname have a 1% adult HIV prevalence rate. In Costa Rica, Mexico and Nicaragua, HIV transmission is mainly through MSM.¹ In Puerto Rico, where HIV transmission has primarily been through drug injection, HIV prevalence among IDUs has declined to

approximately 20%.¹⁶ Several countries in the region have developed or have begun to develop programs to provide access to HAART treatment, notably Argentina, Brazil and Uruguay, and more recently Costa Rica and Panama.¹ Regional organizations have formed to link governments and the international community, to assist with responses to the epidemic and provide wider access to treatment.¹

IMPORTANCE OF CONTINUED SURVEILLANCE

Currently, the World Health Organization is conducting the second phase of a multisite study of injection drug use and HIV in 16 cities internationally (Phase 1 was conducted in 1989-1992 in 12 cities internationally).¹⁷ The Strategic National and International Comparisons Core of CDUHR (D.C. Des Jarlais, Director) serves as the New York City Survey Coordinating Center and is responsible for coordinating the survey component from all sites. In addition, in July 2002, the Global Research Network on HIV Prevention in Drug-Using Populations (GRN) will be convening in Barcelona where updated reports will be presented on the status of HIV/AIDS-drug epidemics in all regions.

It is critical to track prevalence, new infections, risk behaviors and groups at high risk since local, national and regional HIV epidemics are constantly evolving. Targeted prevention and intervention programs have averted and even reversed HIV epidemics among IDUs (e.g., New York). In order to develop timely, effective programs, updated data on the populations at greatest risk for becoming infected are essential. Studies on all types of drug use - IDU, non-injection drug use and alcohol - need to be conducted to examine their impact on HIV-related transmission behaviors.

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2. Needle, R.H., et al. (2000). The Global Research Network on HIV Prevention in Drug-Using Populations (GRN) 1998-2000: Trends in the epidemiology, ethnography, and prevention of HIV/AIDS in injection drug users. In the *GRN third annual meeting report*. Rockville, MD: NIDA.

3. Meeting Highlights (2000). In the *GRN third annual meeting report*. Rockville, MD: NIDA.

4. Rhodes, T., et al. (1999). HIV infection associated with drug injecting in the Newly Independent States, eastern Europe: The social and economic context of epidemics. *Addiction*, 94, 1323-1336.

5. China estimates 850,000 cases HIV infections. Retrieved May 16, 2002 from <http://www.hivandhepatitis.com/recent/statistics/041202g.html>

6. Samson, L., et al. (2000). Are RSAs adequate for intervention development? Evidence from a multicentric RSA on injection drug use in India. In the *GRN third annual meeting report*. Rockville, MD: NIDA.

7. Hien, N.T. (2000). HIV prevalence trends and risk behaviors among injection drug users (IDUs) in Vietnam. In the *GRN third annual meeting report*. Rockville, MD: NIDA.

8. CDC (2001). The global HIV and AIDS epidemic, 2001. *MMWR*, 50 (21), 434-439.

9. Adelekan, M.L. (2000). Injection drug use and associated health consequences in Lagos, Nigeria: Findings from the WHO Phase II Injection Drug Use Study. In the *GRN third annual meeting report*. Rockville, MD: NIDA.

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12. Weiler, G., et al. (2000). Alcohol and risky sexual behavior in Zimbabwe: Preliminary results of a rapid assessment and response (RAR). In the *GRN third annual meeting report*. Rockville, MD: NIDA.

13. CDC (2001). HIV/AIDS surveillance report, Volume 12 (1). Atlanta, GA: CDC.

14. Des Jarlais, D.C., et al. (1998). Declining seroprevalence in a very large HIV epidemic: Injecting drug users in New York City, 1991 to 1996. *American Journal of Public Health*, 88, 1801-1806.

15. European Centre for the Epidemiological Monitoring of AIDS (2001). HIV/AIDS surveillance in Europe. Mid-year report 2001, No. 65. Saint-Maurice: Institut de Veille Sanitaire.

16. Deren, S., et al. (2001). Trends in HIV seroprevalence and needle sharing among Puerto Rican drug injectors in Puerto Rico and New York: 1992-1999. *Journal of Acquired Immune Deficiency Syndromes*, 26, 164-169.

17. Stimson, G., et al. (Eds.) (1998). Drug injection and HIV infection. London: UCL Press.



“The concurrence of self-report of HIV status and biological test results is high for individuals who test HIV negative, but considerably lower for those who test positive. In addition, many individuals who test HIV positive were previously unaware of their HIV status, either because they were never tested for HIV or because they never returned to obtain their test results. Despite the limitations of the self-report of HIV status, there are many situations in which this self-report serves as a reasonable substitute for biological test results.”

Shiela Strauss, Ph.D.,
Principal Investigator

Drug Users' Self-Reported HIV Status: Validity/Methods

Principal Investigator: Shiela M. Strauss, Ph.D.
Funding Agency: NIDA

Background

Determining individuals' HIV status is important for various kinds of research projects including assessments of HIV prevalence and incidence, identification of groups at particularly high-risk for HIV, and evaluations of HIV interventions. For a variety of reasons, it is not always possible to obtain biological test results (e.g., cost of testing, feasibility of obtaining a specimen for testing). When this is the case, self-reports are the only other alternative to determine HIV status. In fact, many studies have identified factors associated with HIV status, or have evaluated HIV interventions, using self-reported HIV status.¹ If there are inaccuracies in self-reporting, however, the results from these studies might be called into question. This project uses a large national dataset to measure the validity of self-report of drug users' HIV status.

When examining HIV self-report validity, it is important to note that the reasons for providing inaccurate self-reports of HIV status are not necessarily due to a lack of truthfulness. For example, this inaccuracy may be due to individuals becoming infected with HIV since their last HIV test. This study is not assessing the truthfulness of self-report, but rather how well self-report reflects the reality of one's true HIV status.

Objectives

The objectives of this study are to determine the:

- Agreement between self-reported HIV status and results from biological testing for HIV
- Extent to which relationships between HIV status and demographic and risk behaviors are accurately assessed if HIV status is obtained from self-report
- Characteristics that differentiate those who report their HIV status and those who do not (because they reported they had not previously been tested for HIV)
- Degree to which relationships between self-reported HIV status and individual characteristics are

correctly assessed by statistically modeling HIV status for those do not report their status.

Participants and Methods

This is a secondary analysis of data from the Cooperative Agreement for AIDS Community-Based Outreach/Intervention Research Program (funded by NIDA). The Cooperative Agreement studies took place from the early to late 1990's at 22 sites in the U.S. and one site in Brazil. At each site, injection drug users (IDUs) and/or crack users, who were not in drug treatment, were street-recruited to assess risk behavior and HIV prevalence, as well as evaluate a standard intervention (pre- and post-test HIV counseling) versus an enhanced intervention to reduce risk behavior. Recent drug use was verified by urinalysis and/or by visible track marks. Face-to-face interviews were administered to obtain information on drug use behavior, sexual risk, HIV testing history and HIV status. Following the interview, participants were provided risk reduction education, pretest counseling for HIV testing, and then offered blood testing and post-test counseling.

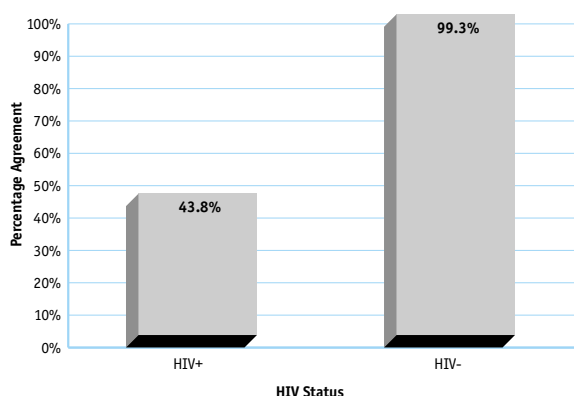
For a site to be included in the analyses for this study, at least 95% of the individuals at the site needed to have been tested for HIV under the Cooperative Agreement study. The individuals tested at these sites were considered to have provided a self-report of their HIV status if they had been tested for HIV in the past, returned for at least one test result, and indicated whether they had ever been told that they had HIV, AIDS-Related Complex (ARC) or AIDS. Ten of the 23 sites met these criteria: Anchorage, AK, St. Louis, MO, San Antonio, TX, Long Beach, CA, Houston, TX, Detroit, MI, Oakland/Richmond, CA, Collier County, FL, San Juan, PR and Miami, FL. This resulted in a combined total of 7,256 participants from the 10 sites who were tested for HIV and gave a self-report of their HIV status.

Findings

Agreement of self-report among those who tested HIV-negative and HIV-positive - Overall the accuracy of self-reported HIV status was high with 93.4% giving a self-report that agreed with their test result across all 10 sites. When the accuracy of self-report is examined separately for those who tested

HIV-negative, specificity (reporting a true negative result) was very high averaging 99.3%, ranging from 98% to 99.9%. Among those who were HIV-positive, self-reported accuracy was lower. Overall, 772 (10.6%) of the sample tested positive for HIV, but only 385 (5.3%) gave a positive self-report. Sensitivity (reporting a true positive result) was low with less than half (43.8%) who tested positive also reporting that they were HIV-positive.¹

Agreement Between Biological Test Results and Self-Reported HIV Status for HIV-Positive and HIV-Negative Individuals



Comparison of low, medium and high HIV prevalence sites among HIV-positives - Concurrence of reporting being HIV positive among low HIV prevalence sites (under 5% prevalence - Anchorage, St. Louis, San Antonio and Long Beach) was 38.9%; among medium HIV prevalence sites (between 6%-19% prevalence - Houston, Detroit, Oakland/Richmond and Collier County) concurrence was lowest at 29%; and among high HIV prevalence sites (over 20% prevalence - San Juan and Miami) concurrence was highest at 52.5%.¹

Characteristics of those who get tested and those who return for test results among HIV-positives - For all participants in the 10 sites who tested HIV-positive, one-third indicated that they had not previously been tested for HIV. Those more likely to have been tested were women, self-identified as gay, lesbian or bisexual, had a history of arrests, were in drug treatment in the past, had an IDU sex partner in the previous month or previously had a sexually transmitted infection. Of those who reported prior HIV testing, 24.1% never returned to obtain a past test result. Those more likely to return for test results were domiciled (not homeless), were married

or in a common-law relationship, or were recruited at a low HIV prevalence site.²

Using self-reported HIV status for research purposes - Additional analyses suggest that even though there are inaccuracies in self-reported HIV status, using self-reports to determine the relationships between individual characteristics and HIV status are usually a reasonable alternative when biological test results are not available.³

Implications and Recommendations

There is high concurrence between drug users' self-reports of HIV status and their test results among those who are HIV-negative and lower concurrence among those who are HIV-positive. With self-reported HIV status, there may be substantial under-reporting of HIV infection. Thus, if self-report is to substitute for biological test results, it is important to determine additional factors that contribute to low concurrence of self-reported HIV status. In addition, different interventions may be needed to: 1) encourage testing, and 2) encourage the return for test results.

For additional information on this study you may contact Shiela Strauss, Ph.D., Principal Investigator - E-mail: shiela.strauss@ndri.org

1. Strauss, S.M., Rindskopf, D.M., Deren, S., & Falkin, G.P. (2001). Concurrence of drug users' self-report of current HIV status and serotest results. *Journal of Acquired Immune Deficiency Syndromes*, 27, 301-307.
2. Strauss, S.M., Deren, S., Rindskopf, D.M., Falkin, G.P. (in press). HIV positive out-of-treatment drug users who are unaware of their status: Predictors of who gets tested and who returns for test results. *Journal of Drug Issues*
3. Strauss, S.M., Rindskopf, D.M., Falkin, G.P., & Deren, S. (2002). Assessing the consequences of using self-report data to determine the correlates of HIV status: An application of standard and nonstandard loglinear modeling. Manuscript in preparation.

CDUHR Pilot Project Award

Zdravko Vassilev, M.D., M.P.H., received a pilot project award for *Highly Active Antiretroviral Therapy for HIV-Positive Drug Users: The Providers' Perspective*. In this project, physicians who provide medical care to HIV-infected patients in NYC will be surveyed to examine: 1) practices and attitudes regarding the use of HAART in drug users, 2) the relationship between patients' drug use status (i.e., active vs. former; newer vs. older; IDU vs. non-injector drug user, methadone maintenance vs. drug-free) and the utilization of HAART, 3) the effect of drug use on patients' adherence and immunologic and virologic response to HAART treatment, and 4) clinician-related strategies to improve drug users' adherence to HAART.

Update on New York State's HIV Reporting and Partner Notification Law

On June 1, 2000 the New York State Department of Health (NYSDOH) implemented the HIV Reporting and Partner Notification Law. In brief, the law requires reporting of cases, by name, of HIV infection, HIV-related illness and AIDS to the NYSDOH.¹ Reporting is required of physicians, other medical providers and clinical laboratories, along with a list of known sexual and needle sharing partners. Cases in New York City are reported to the New York City Department of Health (NYCDOH).

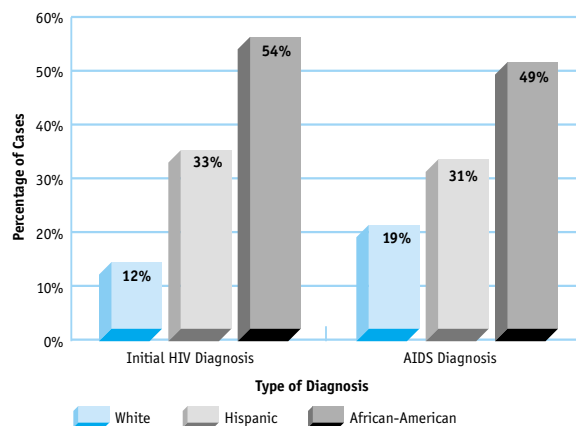
In a report on the implementation of the law, preliminary surveillance data was released by the NYSDOH for cases reported through May 2001 for the period of June 1, 2000 through December 31, 2000.²

A total of 16,866 cases of HIV/AIDS were confirmed in NYS, 72% were among NYC residents. Of the total number of cases in NYS, 17% were initial HIV diagnoses, 53% were HIV-related illness and 30% were AIDS diagnoses. When the cases for NYC are separated from the rest of NYS, the proportions show a similar pattern.

In NYC, 2,145 were initially diagnosed with HIV, of whom 42% were female. Of the 3,497 diagnosed with AIDS, 30% were female. Among those with initial HIV diagnoses, 12% were White, 54% were African-American and 33% were Hispanic. Among those with AIDS diagnoses, 19% were White, 49% were African-American and 31% were Hispanic. In the rest of NYS, the proportions of initial HIV infections and AIDS were similar among African-Americans, higher among Whites and lower among Hispanics.

In NYC, 21% who were initially diagnosed with HIV were 29 or younger. This age group accounted for 8% of the AIDS cases. The highest proportion was among the 30-39 age category with 39% initial HIV diagnoses. Among AIDS cases, the largest proportion of cases (36%) were among those between the ages of 40-49 and 30-39 (35%).

**Newly Diagnosed HIV and AIDS Cases in NYC:
June 1, 2000 – December 31, 2000 by
Race/Ethnic Group**



In areas outside NYC, PartNer Assistance Program (PNAP) staff (comprised of NYSDOH and county health department staff) contact providers to offer partner notification assistance even if the provider does not request assistance. In NYC, Contact Notification Program (CNAP) staff contact only those providers who request CNAP assistance. In NYC, 50% of reports include partner notification information (compared with 60% for the rest of NYS). In NYC, 23% of partners (14% for the rest of NYS) could not be notified because of insufficient locator information. Reporting forms are being revised to allow for more specific locating information to be included. A total of 2% of notifications, for the entire state, were deferred due to domestic violence concerns.

HIV infection by risk category was not available since the reports do not include this information. This information will be reported following full chart reviews of all cases.

Although these findings are preliminary, the HIV reporting law has greatly increased the number of known HIV cases in the state. Of concern are the disproportionate number of new infections among African-Americans and Hispanics. In addition, in order to develop effective prevention and intervention programs, more timely reporting of risk categories is crucial.

1. The complete regulations can be found at the NYSDOH Web site at: <http://www.health.state.ny.us/nysdoh/aids/index.htm>
 2. New York State Department of Health (2002, March). Implementation of the New York State HIV Reporting and Partner Notification Law: Report on activities conducted 6/1/2000 through 12/31/2000. Unpublished report.

December 2001 - May 2002

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The Training Institute

The Training Institute provides training for the New York State Department of Health AIDS Institute and conducts courses by special request. Following are courses available from August - December 2002, offered at no cost. All courses are held at the NDRI main offices unless otherwise noted.

Date	Course
8/13, 12/12	Cultural Diversity Training for Case Managers (One day)
8/20, 10/1 ^a	Overview of HIV Infection and AIDS (3 hours)
8/20, 10/1 ^a	HIV & STDs (3 hours)
8/27, 10/21 ^b	HIV/AIDS Update (3 hours)
8/27, 10/21 ^b	HIV Confidentiality Law (3 hours)
9/4, 11/13	Basic Information About Domestic Violence (One day)
9/9-9/10, 11/18-11/19	HIV Testing Procedures (Two days)
9/12, 11/20	Practicing the New York State Domestic Violence Screening Protocol (3 hours)
9/16 ^c	Implementing HIV Reporting and Partner Notification (One day)
9/18, 11/26 ^c	Domestic Violence in Lesbian, Gay, Bisexual and Transgender Communities (One day)

Date	Course
9/23-9/26, 11/4-11/7	Community HIV/AIDS Educator Training (Four days)
10/2, 12/5	Promoting Adherence to HIV Treatment (3 hours)
10/2, 12/5	HIV Treatment Fraud (3 hours)
10/7-10/9	Reducing the Risk and Harm of HIV (Three days)
10/15, 12/3	Introduction to Case Management (One day)(For COBRA case management)
10/17 ^a	Reducing Perinatal Transmission in Prenatal, Maternity and Newborn Settings (3 hours)
10/22, 12/10	Enhancing the Partnership Between Client and Case Manager (One day)
10/29-10/30	Serving Families: From Assessment to Service Plan (1½ days)

a Lincoln Hospital, Bronx
 b Woodhull Hospital, Brooklyn
 c Bronx AIDS Services

These courses are eligible for contact hours for CASAC credentialing. For a complete listing of Year 2002 courses, the curriculum of Special Request courses, CDUHR/Training Institute courses, and information on the courses listed above, call the Training Institute at (212) 845-4564. This information is also available on our Web site at <http://www.ndri.org> where you may register for these courses.

CDUHR is funded by the National Institute on Drug Abuse to provide an infrastructure to support the HIV/AIDS-related research projects at NDRI. It is the first center for the socio-behavioral study of drug use and HIV in the United States and is dedicated to increasing our understanding of the drug use-HIV epidemic.

CDUHR Core Directors

Administration and Coordination Core
Sherry Deren, Ph.D.

Project Development Core
Holly Hagan, Ph.D.

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Shiela M. Strauss, Ph.D.

Strategic National and International Comparisons Core
Don C. Des Jarlais, Ph.D.

Social Theory Core
Samuel R. Friedman, Ph.D.

Training and Dissemination Core
Andrew Osborne, M.S. Ed., CHES

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CDUHR Supported Projects

Collaborative Injection Drug Users III: Drug User Intervention Trial (CDC)
Principal Investigator: Holly Hagan, Ph.D. (Seattle PI)

Community Vulnerability and Response to HIV (NIDA)
Principal Investigator: Samuel R. Friedman, Ph.D.

Cross-Border HIV Prevention Project: China and Vietnam (NIDA)
CDUHR Co-Investigator: Don C. Des Jarlais, Ph.D. PI: T. Hammett, Ph.D.

Drug Users' Self-Reported HIV Status: Validity/Methods (NIDA)
Principal Investigator: Shiela M. Strauss, Ph.D.

Etiology and Prevention of Blood-Borne Viruses in IDUs (NIDA)
Principal Investigator: Holly Hagan, Ph.D.

Expanded Syringe Access Program: NY Evaluation (NIDA)
CDUHR Co-Investigator: Sherry Deren, Ph.D. PI: D. Vlahov, Ph.D.

HCV Service Innovations in Drug Treatment Programs (NIDA)
Principal Investigator: Shiela M. Strauss, Ph.D.

Hispanic Heroin Users, Transitions to Injecting and HIV (NIDA)
CDUHR Co-Investigator: Alan Neaigus, Ph.D. PI: A. Valdez, Ph.D.

HIV Risk Behaviors Among Urban Nomad Drug Injectors (NIDA)
Principal Investigator: Don C. Des Jarlais, Ph.D.

Interventions for HIV-Positive Mothers with Drinking Problems (NIAAA)
Principal Investigator: Marya Viorst Gwadz, Ph.D.

Local Context, Social Control Action and HIV Risk: Phase 1 (NIMH)
Principal Investigator: Samuel R. Friedman, Ph.D.

Measuring Sexual Minority Status Among Women Drug Users (NIDA)
Principal Investigator: Rebecca M. Young, Ph.D.

National Study of Syringe Exchange Programs (NIDA)
Principal Investigator: Don C. Des Jarlais, Ph.D.

Networks, Norms, and HIV/STI Risk Among Youth (NIDA)
Principal Investigator: Samuel R. Friedman, Ph.D.

Network Risks Among New IDUs in New York and Marseilles (NIDA)
Principal Investigator: Alan Neaigus, Ph.D.

Non-Injecting Heroin Users, New Injectors and HIV Risk (NIDA)
Principal Investigator: Alan Neaigus, Ph.D.

Puerto Rican Drug Users in NY and PR: HIV Risk Behavior Determinants (NIDA)
Principal Investigator: Sherry Deren, Ph.D.

Risk Factors for AIDS Among IDUs (NIDA)
Principal Investigator: Don C. Des Jarlais, Ph.D.

Study to Reduce Intravenous Exposures (NIDA)
Principal Investigator: Holly Hagan, Ph.D. (Seattle PI)

Treatment Engagement of HIV Positive Heroin Users (SAMHSA-CSAT)
Principal Investigator: Marjorie F. Goldstein, Ph.D.

UAB-NDRI-Substance Abuse ICOHRTA in Ukraine (NIDA)
CDUHR Co-Directors: Sherry Deren, Ph.D. and Samuel R. Friedman, Ph.D. PI: S. Vermund, M.D., Ph.D.

United Bronx Parents La Casita Therapeutic Community Evaluation (NYS OASAS, NYSDOH)
Principal Investigator: Don C. Des Jarlais, Ph.D.

WHO Survey Coordinating Center, Drug Injecting Study- Phase 2 (WHO)
Principal Investigator: Don C. Des Jarlais, Ph.D.

Women Drug Users, Their Male Partners and HIV Risk (NIDA)
Principal Investigator: Stephanie Tortu, Ph.D.