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CDUHR news

Center for Drug Use and HIV Research
in the Institute for AIDS Research at National Development and Research Institutes, Inc.

Despite many evidence-based effective interventions at the individual level, greater success in HIV prevention may be achieved by addressing social-level factors as well.

Social-Level Influences on HIV Risk Among Drug Users

Since the beginning of the HIV/AIDS epidemic among drug users, epidemiological and social science research on factors influencing HIV transmission have focused primarily on behaviors and other factors that characterize the individual. A substantial body of research has identified individual-level variables that increase HIV risk among injection drug users (IDUs) (e.g., frequency of shooting gallery use) and factors that reduce risk (e.g., enrollment in drug treatment, use of syringe exchange). As our understanding of individual-level characteristics has become more sophisticated, however, it has become clear that an understanding of social-level factors is also needed to explain variation in HIV incidence. Despite many evidence-based effective interventions at the individual level,[1] greater success in HIV prevention may be achieved by addressing social-level factors as well. Social-level influences include networks (which may be social or risk networks), community-level factors, social structures, public health policies and sociopolitical factors. The social context of risk behaviors is important both to transmission behaviors (e.g., risk networks) and to the existence of HIV control measures (e.g., public health policies).

Due to the growing recognition of the importance of these factors, and their increasing inclusion in CDUHR projects, brief descriptions of various types of social-level influences and some examples of interventions are provided.

Networks

Risk networks consist of those people with whom HIV risk behaviors occur. Social networks consist of those people who shape each other's behavior, such as friends and family. Social influences on risk usually emanate from risk and social networks, and include peer norms which may promote or inhibit HIV risk behaviors. Examples of network interventions include recruiting drug injectors to bring in persons with whom they had injected to discuss HIV risks and how they can be reduced,[2] and allowing users of a syringe exchange to exchange large numbers of syringes which can be distributed to friends or contacts who in turn may distribute them to others.[3]

Community Mobilization Efforts

Community-level influences include broad social norms regarding the acceptability of risk or protective behaviors. Community interventions are a form of social movement, and usually involve immediate challenges to the influence of some local formal and/or informal leaders. A key example of a social movement that promoted risk reduction has been the mobilization among gay and lesbian communities in response to AIDS, which is considered one of the most effective health interventions for HIV prevention.[4,5] Injection drug users have organized

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Social Levels of Influence on HIV Risk

1. Networks (risk or social) includes dyads, peers, families
2. Community (metropolitan area, city, neighborhood) and organizational level
3. Social structures and institutions (e.g., race/ethnicity and gender as structures of subordination)
4. Public health policies and programs
5. Socioeconomic and sociopolitical context (e.g., cultural, capital, political influences)

We would like to acknowledge the contributions to this article by Sam Friedman, Ph.D., Director, and Rebecca Young, Ph.D., Deputy Director, Social Theory Core, CDUHR.

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small-scale movements in many localities. For example, some of the *junkiebonden* in the Netherlands set up their own mechanisms for the distribution of methadone when they believed that established drug-treatment facilities were prescribing dosages too low to block the craving for heroin.[6] In addition, underground needle exchanges were established in localities where provision of clean needles was illegal.

Racial, Gender and Sexual Subordination

Sexuality, homophobia, and associated stigmas and subordinations are associated with risk behaviors among IDUs[7] and with both social and risk network patterns.[8] Gender inequality in sexual and injecting relationships exacerbates women's increased biological vulnerability to HIV via sex with men.[9] Racial subordination and ethnicity are associated with HIV infection, risk behaviors, and prevention efforts in complex ways and are manifested at a number of social-levels. For example, social stratification may be manifested in the form of racial/ethnic subordination,[10] which shapes networks and affects interpersonal relationships and personal behaviors which impact HIV risk.[11] Examples of interventions addressing gender inequalities are holding "women-only" hours at syringe exchange programs, or improving access to women-controlled barrier methods for preventing sexual transmission of HIV (e.g., female condoms and microbicides).

Public Health Policies and Programs

Sometimes referred to as structural influences, these consist of programs or policies that change the environment where HIV risk occurs without attempting to change knowledge, attitudes or social interaction patterns of individuals.[12] Examples include policies that may make safer behavior easier (e.g., legalizing over-the-counter syringe sales without prescriptions or increasing funding for drug treatment programs), or that target the immediate social context of risk behaviors by changing the environment within which they occur (e.g., establishment of safer injection rooms in Europe or requirement of condom use in Thai brothels).

Socioeconomic and Sociopolitical Factors

These macro-level influences can also encourage or inhibit behaviors related to transmission, but are often the most difficult to affect. Communities with more income inequality and those undergoing significant social and political transition (e.g., the breakup of the former Soviet Union in the 1990s) have been found to have higher HIV rates.[13] In addition, although several mechanisms have been studied and found to reduce the spread of HIV, lack of resources, political opposition, and/or other barriers have prevented their being implemented in many localities (e.g., outreach, methadone treatment and syringe exchange programs). Research is needed to understand conditions and actions that influence sociopolitical factors and make public health policies and programs more or less likely to be implemented on a scale great enough to affect the HIV epidemic.[14]

1. National Institute on Drug Abuse (2002). Principles of HIV prevention in drug using populations: A research-based guide (NIH No. 02-4733). Rockville, MD: National Institutes of Health.
2. Latkin, C.A., et al. (1996). The long-term outcome of a personal network-oriented HIV prevention intervention for injection drug users: The SAFE study. *American Journal of Community Psychology, 24*, 341-364.
3. Valente, T.W., et al. (1998). Satellite exchange in the Baltimore needle exchange program. *Public Health Reports, 113* (Supplement 1), 90-96.
4. Altman, D. (1991). The primacy of politics: Organizing around AIDS. *AIDS, 5*, S231-S238.
5. Wohlfeiler, D. (2000). Structural and environmental HIV prevention for gay and bisexual men. *AIDS, 14* (Supplement 1), S52-S56.
6. Friedman, S.R., & Des Jarlais, D.C. (1993). Re: "The harm reduction approach and risk factors for human immunodeficiency virus (HIV) seroconversion in injecting drug users, Amsterdam". *American Journal of Epidemiology, 138* (9), 768-771.
7. Young, R. M., et al. (2000). Women injection drug users who have sex with women exhibit increased HIV infection and risk behaviors. *Journal of Drug Issues, 30* (3), 499-524.
8. Friedman, S.R., et al. (2001) HIV prevalence, social marginalization, risk behaviors, and high-risk sexual injection networks among young women injectors who have sex with women. Presented at the International Conference on the Reduction of Drug Related Harm, New Delhi, India.
9. Zierler, S., & Krieger, N. (1997). Reframing women's risk: Social inequalities and HIV infection. *Annual Reviews of Public Health, 18*, 401-436.
10. Friedman, S. R., et al. (1999). Similarities and differences by race/ethnicity in changes of HIV seroprevalence and related behaviors among drug injectors in New York City, 1991-1996. *Journal of Acquired Immune Deficiency Syndromes, 22*, 83-91.
11. Friedman, S. R., et al. (1999). *Social networks, drug injectors' lives, and HIV*. New York: Plenum.
12. Des Jarlais, D.C. (2000). Structural interventions to reduce HIV transmission among injecting drug users. AIDS, 14 (Supplement 1), S41-S46.
13. Kalipeni, E. (2000). Health and disease in southern Africa: A comparative and vulnerability perspective. *Social Science and Medicine, 50* (7-8), 965-983.
14. Nathanson, C. (1996). Disease prevention as social change: Toward a theory in public health. *Population and Development Review, 22*, 609-637.

Knowledge of the trends of the New York City IDU epidemic is due, in large part, to findings from the *Risk Factors for AIDS among IV Drug Users* project. The project, which began in 1983, is the longest continuous study of IDUs and HIV in the world.

Risk Factors for AIDS among IV Drug Users

Principal Investigator: Don C. Des Jarlais, Ph.D.
Funding Agency: NIDA

Background

The HIV epidemic in New York City (NYC) among injection drug users (IDUs) has been the largest and earliest local epidemic in the world. With over 54,000 AIDS cases among IDUs in the city,[1] it accounts for nearly one quarter of all IDU cases in the U.S. and approximately one-tenth of all cases in the U.S. The NYC epidemic has unfolded in different phases: 1) the virus was introduced into the IDU population by the mid 1970s; 2) there was rapid spread of infections during the late 1970s and early 1980s; 3) a period of stability in prevalence (around 50%) in the mid 1980s, into the early 1990s; [2] and 4) declining prevalence and incidence from the early 1990s to the present.[3, 4] Knowledge of the trends of the New York City IDU epidemic is due, in large part, to findings from the *Risk Factors for AIDS among IV Drug Users* project. The project, which began in 1983, is the longest continuous study of IDUs and HIV in the world.

Objectives

The current aims of this ongoing project are to study:

- Long-term trends in prevalence and incidence among IDUs in NYC
- Long-term trends in HIV risk behaviors among IDUs in NYC and characteristics of users who continue or relapse to high-risk behavior
- Social networks and "mixing" patterns among IDUs, and how these relate to HIV infection and risk behavior
- Transitions between non-injecting drug use and injecting drug use and characteristics of new injectors
- Audio-computer assisted self-interviewing (A-CASI) as a method for obtaining information from participants.

Participants and Methods

Participants are recruited from a drug detoxification and methadone maintenance treatment program (MMTP) at Beth Israel Medical Center (BIMC) in Manhattan, New York City. Individuals are eligible for participation if they reported injecting drugs in the previous six months. Over 95% of potential participants who were approached for recruitment into the project agreed to participate. Interviewers administer a questionnaire based on one developed for the World Health Organization Multi-Centre Study of AIDS and Injecting Drug Use.[5]

The data analyses reported here are based on several studies, indicating trends in the NYC epidemic. They include a parallel project of participants from the first two phases of the Collaborative Injection Drug Users Studies (CIDUS) recruited through street outreach or peer referral from a Lower East Side (LES), New York City research storefront (funded by CDC, D.C. Des Jarlais, PI, NY site).

Findings

HIV prevalence rates – Based on analyses from five different NYC studies between 1991-1996, there were clear trends of lower HIV prevalence across all studies to approximately 30% by 1996. Over the six years, the prevalence rates corresponded to reductions of roughly 2-3% per year.[3] More recent analysis from data collected from the BIMC detoxification program (1996-2001) showed that HIV prevalence declined from 38% to 13%.[4]

HIV incidence rates – Based on analyses from 10 different studies between 1992-1997, the average incidence rate was approximately 1 per 100 person-years at risk.[6] In comparison, in a previous study of HIV incidence among New York City IDUs, between 1985 and 1992, a rate of 4.4 per 100 person-years at risk was found.[7]

HIV risk behavior (previous six months) – Between 1990 and 2001, use of syringe exchange increased (from approximately 13% to 37%), as did reports of having ever been tested for HIV (from around 56% to 91%). During this time period, injection risk behavior declined (between 1990-1996), and stabilized between 1997-2001. Receptive needle sharing (using other's needles) declined from 50% (in 1990) to around 25% (1996), and increased to 40% by 2001; distributive needle sharing (giving one's used needles to others to use), decreased from

(Continued next page.)

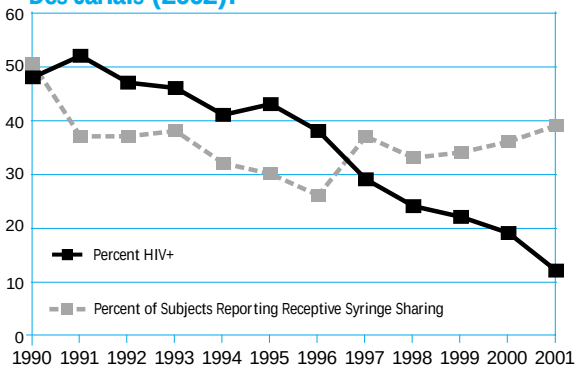
approximately 59% to 27%, and remained stable at approximately 34% in 2001. The results on sexual risk showed similar patterns. Self-reported unsafe sex with a casual partner declined from approximately 22% to 9%, and increased slightly to 12%; unsafe sex with a primary partner declined from 48% to 30%, and increased to 40% in 2001.[4]

Differences by race/ethnicity in HIV prevalence – From 1990-2001, HIV prevalence declined for all race/ethnic groups. Whites, however, were less likely to be infected during this time period than African-Americans and Hispanics. For example, in the early 1990's over 50% of African-American and Hispanic IDUs were HIV-positive compared to 17% and 13%, respectively, in 2001. For Whites, prevalence declined from approximately 30% in the early 1990's to 10% in 2001.[4]

HIV prevalence and risk behavior among IDU men who have sex with men (MSM) – Two periods were examined: 1990-1994 and 1995-1999. MSM comprised approximately 6% of the total sample of IDU men. In the first time period, HIV prevalence was higher among MSM compared to non-MSM (60.5% vs. 48.3%). It declined for both groups by the second time period, but continued to remain higher among MSM (43.8% vs. 33.4%). Over time, both groups were more likely to use a syringe exchange and less likely to engage in distributive and receptive needle sharing. However, in both time periods, MSM were more likely than non-MSM to engage in receptive needle sharing (e.g., 41.4% vs. 28.6% for the latter period). For sexual risk, the percentage of MSMs who started or increased

(Top, from left to right) Sam Friedman, Ph.D., Co-Investigator, Theresa Perlis, Ph.D., Project Director, Carole Johnson, Research Associate, Loren Vangelatos, Interviewer (Bottom, from left to right) Martha Nelson, Interviewer, Kamyar Arasteh, Ph.D., Data Analyst

HIV Prevalence and Receptive Syringe Sharing among IDUs, 1990–2001. Graph adapted from Des Jarlais (2002).[4]



condom use was similar in both time periods (62.9% and 58.8%), while it increased among non-MSM (45.4% and 53.6%).[8]

Implications and Recommendations

Collectively, these studies suggest that is possible to reverse the course of a large IDU HIV epidemic with appropriate prevention programs. While many of the trends are clearly positive, this is not an indication that the HIV epidemic among IDUs in New York City is over. While injection risk and sexual risk behavior declined in the mid-1990s, more recent data indicates that these risk behaviors may have stabilized. It remains to be seen if the declining HIV prevalence rates can be sustained. However, the lessons learned from the NYC epidemic may be important for regions currently experiencing HIV epidemics largely driven by injection drug use.

1. New York City Department of Health, HIV/AIDS Surveillance Program (2001). AIDS surveillance update in NYC - 4th quarter 2000. New York: New York City Department of Health.

2. Des Jarlais, D.C., Friedman, S.R., Sotheran, J.L., Wenston, J., Marmor, M., Yancovitz, S.R., Frank, B., Beatrice, S., & Mildvan, D. (1994). Continuity and change within an HIV epidemic: Injecting drug users in New York City, 1984 through 1992. Journal of the American Medical Association, 271, 121-127.

3. Des Jarlais, D.C., Perlis, T., Friedman, S.R., Deren, S., Chapman, T., Sotheran, J.L., Tortu, S., Beardsley, M., Paone, D., Torian, L.V., Beatrice, S.T., DeBernardo, E., Monterroso, E., Marmor, M. (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.

4. Des Jarlais, D.C. (2002, July). Trends in HIV among IDUs in New York City. Presented at the International AIDS Conference, Barcelona, Spain.

5. Stimson, G., Des Jarlais, D.C., & Ball, A. (Eds.) (1998). Drug injection and HIV infection. London: UCL Press.

6. Des Jarlais, D. C., Marmor, M., Friedmann, P., Titus, S., Aviles, E., Deren, S., Torian, L., Glebatis, D., Murrill, C., Monterroso, E., & Friedman, S. R. (2000). HIV incidence among injection drug users in New York City, 1992-1997: Evidence for a declining epidemic. American Journal of Public Health, 90, 352-359.

7. Holmberg, S. (1996). The estimated prevalence and incidence of HIV in 96 large US metropolitan areas. American Journal of Public Health, 86, 642-654.

8. Maslow, C. B., Friedman, S. R., Perlis, T. E., Rockwell, R., & Des Jarlais, D. C. (2002). Changes in HIV seroprevalence and related behaviors among male injection drug users who do and do not have sex with men: New York City, 1990-1999. American Journal of Public Health, 92, 382-384.

For additional information on this study you may contact Theresa Perlis, Ph.D., Project Director - E-mail: theresa.perlis@ndri.org.

CDUHR STAFF ANNOUNCEMENT

Michele Shedlin Joins CDUHR

Michele Shedlin, Ph.D., joined CDUHR in June 2002. Dr. Shedlin is a medical anthropologist experienced both nationally and internationally in qualitative medical and public health research. As a university-based researcher and as President of Sociomedical Resource Associates, she provided teaching, training and research expertise in the areas of reproductive health, drug use and HIV/AIDS. She has developed and directed studies in the U.S., Africa and Latin America focusing on cultural factors relevant to the design, implementation and evaluation of culturally appropriate interventions and services.

Her years of experience in Latin America and with Latino populations in the U.S. have been instrumental in previous consulting work with CDUHR in New York, Puerto Rico and the Dominican Republic. She joins CDUHR as the Principal Investigator of two NIH-funded projects: *Drug Use and HIV Risk in Nicaragua* (NIDA) and *New Hispanic Immigrants and HIV Risk* (NICHD) (see below for descriptions). She is also Associate Director of International and Immigrant Health Research in the Strategic National and International Comparisons Core of CDUHR. In addition, Dr. Shedlin is directing a qualitative evaluation study of HIV treatment services at Columbia-Presbyterian Medical Center. She maintains adjunct faculty positions at Columbia University, the University of Houston, the University of Texas and the University of Connecticut.

NEW CDUHR PROJECTS

In this section of the newsletter, information regarding newly funded research projects, since June 2002, are described.

Drug Use and HIV Risk in Nicaragua (NIDA)

Principal Investigator:
Michele G. Shedlin, Ph.D.

In Nicaragua, many of the preconditions which may lead to a large HIV epidemic exist, including displacement due to political instability and natural disasters, presence of migrants and other mobile populations, shared borders with countries which have major HIV epidemics and increased sex work in areas with high concentrations of transient workers. In addition, there are indicators that drug trafficking is influencing local drug use along with a lack of basic HIV/AIDS information and education. Currently, there is no systematic HIV surveillance, low levels of HIV testing and little information on drug use in the country.

This exploratory study will research drug use patterns in Managua, Nicaragua and will be conducted through Nimehautzin, the leading HIV/AIDS organization in the country. The study will: 1) identify methods of reaching drug using populations, 2) provide descriptions of patterns of drug use, 3) explore how drug use influences HIV transmission, and 4) develop institutional capacity to conduct behavioral research in drug use and HIV. Findings will inform HIV prevention efforts and the development of new interventions.

New Hispanic Immigrants and HIV Risk (NICHD)

Principal Investigator:
Michele G. Shedlin, Ph.D.

Research on mobile populations indicates that studying these groups is important to enhance our understanding of HIV transmission. Large numbers of Hispanics have migrated to the New York City area from Mexico, Central America and the Caribbean, where HIV prevalence has been increasing. Few studies have examined HIV risk behaviors among new immigrant populations in the U.S.

This ethnographic study is being conducted among recently arrived immigrants from Mexico, El Salvador, Honduras, Guatemala and the Dominican Republic. Participants will be recruited from suburban (Westchester, Putnam and Rockland Counties) and rural (the North Fork area of Suffolk County) areas of New York State. The study will describe and compare HIV drug and sex risk behavior and access to HIV prevention services. It will also examine the cultural factors that influence HIV risk and the environmental factors that provide the contexts for risk and protective behaviors. *(Continued next page.)*

Measuring HIV/AIDS Knowledge Among the Deaf (NIMH)

Principal Investigator:
Marjorie F. Goldstein, Ph.D.

There is evidence that deaf persons have less accurate HIV/AIDS knowledge than do hearing persons. Several factors may contribute: low literacy, lack of educational materials in American Sign Language (ASL), limitations of lip-reading, and confidentiality issues when interpreters are used. These factors also form barriers to interviewing deaf persons. Phase 1 of this project (Elizabeth Eckhardt, M.S.W., PI) tested the feasibility of interviewing deaf persons about HIV/AIDS and identified English-to-ASL translation challenges. Results of several focus groups indicated that deaf individuals would feel comfortable answering HIV/AIDS-related questions in ASL on computer. Recommendations regarding questionnaire response formats, especially Likert scales, were developed.

In Phase 2, HIV/AIDS-related knowledge, attitudes and risk behavior questions will be translated into ASL, videotaped, captioned, and digitized for computerized administration. The questionnaire will be self-administered on notebook computer to several hundred deaf participants. Two levels of ASL will be available, one for proficient signers and another for those whose first language is neither ASL nor English. This latter group is particularly disadvantaged as they have difficulty accessing information in both ASL and English.

CDUHR STAFF PUBLICATIONS

June 2002 - November 2002

Deren, S., Efthimiou-Mordaunt, A., Rhodes, F., & Levy, J. A. (2002). Prevention of HIV among drug users. *Substance Use and Misuse, 37* (8-10), 1215-1227.

Deren, S., Shedlin, M., Hamilton, T., & Hagan, H. (2002). Impact of the September 11th attacks in New York City on drug users: A preliminary assessment. *Journal of Urban Health, 79* (3), 409-412.

Des Jarlais, D. C., & Friedman, S. R. (2002). Strategies for working with injecting drug users: The role of health psychologists in harm reduction. In M. A. Chesney, & M. H. Antoni (Eds.), *Innovative approaches to health psychology: Prevention and treatment lessons from AIDS* (pp. 97-114). Washington, D.C.: American Psychological Association.

Des Jarlais, D. C., Friedmann, P., Grund, J-P., Milliken, J., Titus, S., Zadoretsky, C., Perlis, T., Bodrova, V., & Zemlianova, E. (2002). HIV risk behaviour among participants of syringe exchange programmes in central/eastern Europe and Russia. *International Journal of Drug Policy, 12* (3), 165-170.

Des Jarlais, D. C., & Hubbard, R. L. (2002). Alcohol and drug abuse. In R. Detels, J. McEwen, R. Beaglehole, & H. Tanaka (Eds.), *Oxford textbook of public health. Volume 3* (4th ed., pp. 1503-1520). London: Oxford University Press.

Des Jarlais, D. C., & Semaan, S. (2002). HIV prevention research: Cumulative knowledge or accumulating studies? An introduction to the HIV/AIDS Prevention Research Synthesis project supplement. *Journal of Acquired Immune Deficiency Syndromes, 30* (Supplement), S1-S7.

Feng, C., & Des Jarlais, D. (2002). HIV among drug users in China. *Science, 298* (5596), 1171.

Friedman, S. R., Flom, P. L., Kottiri, B. J., Neaigus, A., Sandoval, M., Fuld, J., Curtis, R., Zenilman, J. M., & Des Jarlais, D. C. (2002). Consistent condom use among drug-using youth in a high HIV-risk neighbourhood. *AIDS Care, 14* (4), 493-507.

Friedman, S. R., Flom, P. L., Kottiri, B. J., Sandoval, M., Neaigus, A., Maslow, C. B., Mateu-Gelabert, P., Zenilman, J., Des Jarlais, D. C., & Barth-Jones, D. C. (2002). Networks, norms and HIV risk in New York City. In *The network paradigm in research on drug abuse, HIV, and other blood-borne and sexually transmitted infections: New perspectives, approaches and applications. NIDA/CAMCODA Working Meeting* (pp. 41-47). Rockville, MD: National Institute on Drug Abuse.

Friedman, S. R., Neaigus, A., Sandoval, M., Mateu-Gelabert, P., Flom, P. L., Kottiri, B. J., Fuld, J., Krauss, B., & Des Jarlais, D. C. (2002). What risk networks and social networks can contribute to understanding and preventing the spread of HIV. In *2001 Global Research Network meeting on HIV prevention in drug-using populations: Fourth Annual Meeting Report* (pp. 19-25). Rockville, MD: National Institute on Drug Abuse.

2002 RESEARCH SUPPLEMENT AWARDS

NIH (National Institutes of Health) supplements were awarded to four CDUHR projects. *Etiology and Prevention of Blood-Borne Viruses in IDUs* (H. Hagan, PI) received its award to measure HIV, hepatitis B and hepatitis C seroprevalence among IDUs in Sofia, Bulgaria. In addition, it will compare these rates to other countries in the region that have not implemented syringe exchange programs. *HCV Service Innovations in Drug Treatment Programs* (S. Strauss, PI) was awarded a supplement to determine (a) the comprehensiveness of HIV/AIDS-related services (e.g., testing, counseling, education) offered by drug treatment programs; and (b) the relationship between the programs' provision of HCV services and HIV/AIDS-related services. *Networks, Norms, and HIV/STI Risk Among Youth* (S. Friedman, PI) received a supplement for *Networks, Norms and Risk in Argentina's Social Turmoil*. It will assess peer and family norms towards drug use and sex, and document sexual and drug risk networks and behaviors among young IDUs and other young adults in a high-risk neighborhood in Buenos Aires. *Puerto Rican Drug Users in NY and PR: HIV Risk Behavior Determinants* (S. Deren, PI) received a supplement to develop a multi-level intervention to reduce HIV risk behaviors which is tailored to drug users at two different sites – New York and Puerto Rico.

Friedman, S. R., & Reid, G. (2002). The need for dialectical models as shown in the response to the HIV/AIDS epidemic. *International Journal of Sociology and Social Policy, 22* (4/5/6), 177-200.

Gyarmathy, V. A., Neaigus, A., Miller, M., Friedman, S. R., & Des Jarlais, D. C. (2002). Risk correlates of prevalent HIV, hepatitis B virus, and hepatitis C virus infections among noninjecting heroin users. *Journal of Acquired Immune Deficiency Syndromes, 30* (4), 448-456.

Hagan, H., Thiede, H., McGough, J. P., & Alexander, E. R. (2002). Hepatitis B vaccination among research participants, Seattle, Washington. *American Journal of Public Health, 92* (11), 1756.

Hankins, C. A., Friedman, S. R., Zafar, T., & Strathdee, S. A. (2002). Transmission and prevention of HIV and sexually transmitted infections in war settings: Implications for current and future armed conflicts. *AIDS, 16* (17), 2245-2252.

Hu, D. J., Subbarao, S., Vanichseni, S., Mock, P. A., van Griensven, F., Nelson, R., Nguyen, L., Kitayaporn, D., Young, N. L., Des Jarlais, D., Byers, R., Choopanya, K., & Mastro, T. D. (2002). Higher viral loads and other risk factors associated with HIV-1 seroconversion during a period of high incidence among injection drug users in Bangkok. *Journal of Acquired Immune Deficiency Syndromes, 30* (2), 240-247.

Kapadia, F., Vlahov, D., Des Jarlais, D. C., Strathdee, S. A., Ouellet, L., Kerndt, P., Morse, E. V., Williams, I., & Garfein, R. S. (2002). Does bleach disinfection of syringes protect against hepatitis C infection among young adult injection drug users? *Epidemiology, 13* (6), 738-741.

Karapetyan, A. F., Sokolovsky, Y. V., Araviyskaya, E. R., Zvartau, E. E., Ostrovsky, D. V., & Hagan, H. (2002). Syphilis among intravenous drug-using population: Epidemiological situation in St. Petersburg, Russia. *International Journal of STD and AIDS, 13* (9), 618-623.

Oliver-Velez, D., Finlinson, H. A., Deren, S., Robles, R. R., Shedlin, M., Andia, J., & Colón, H. (2002). Mapping the Air-Bridge locations: The application of ethnographic mapping techniques to a study of HIV risk behavior determinant in East Harlem, New York, and Bayamon, Puerto Rico. *Human Organization, 61* (3), 262-276.

Pearson, F. S., Lipton, D. S., Cleland, C. M., & Yee, D. S. (2002). The effects of behavioral/cognitive-behavioral programs on recidivism. *Crime and Delinquency, 48* (3), 476-496.

Quaglio, G., Talamini, G., Lugoboni, F., Lechi, A., Venturini, L., Des Jarlais, D. C., & Mezzelani, P. (2002). Compliance with hepatitis B vaccination in 1175 heroin users and risk factors associated with lack of vaccine response. *Addiction, 97* (8), 985-992.

Rosario, M., Schrimshaw, E. W., Hunter, J., & Gwadz, M. (2002). Gay-related stress and emotional distress among gay, lesbian, and bisexual youths: A longitudinal examination. *Journal of Consulting and Clinical Psychology, 70* (4), 967-975.

Semaan, S., Des Jarlais, D. C., Sogolow, E., Johnson, W. D., Hedges, L. V., Ramirez, G., Flores, S. A., Norman, L., Sweat, M. D., & Needle, R. (2002). A meta-analysis of the effect of HIV prevention interventions on the sex behaviors of drug users in the United States. *Journal of Acquired Immune Deficiency Syndromes, 30* (Supplement), S73-S93.

Semaan, S., Kay, L., Strouse, D., Sogolow, E., Mullen, P. D., Neumann, M. S., Flores, S. A., Peersman, G., Johnson, W. D., Lipman, P. D., Eke, A., & Des Jarlais, D. C. (2002). A profile of US-based trials of behavioral and social interventions for HIV risk reduction. *Journal of Acquired Immune Deficiency Syndromes, 30* (Supplement), S30-S50.

The NDRI Training Institute

The NDRI Training Institute (A. Osborne, Director) provides training for the New York State Department of Health AIDS Institute and conducts courses by special request. Following are courses available from January–June 2003, offered at no cost. All courses are held at the NDRI main offices unless otherwise noted.

Date	*Course*
1/6, 4/7[a]	◆ Overview of HIV Infection and AIDS (3 hours)
1/13, 4/14	HIV Confidentiality Law (3 hours)
1/13, 4/14	HIV Disclosure (3 hours)
1/22[b], 4/16	◆ Basic Information About Domestic Violence (One day)
1/27-1/28, 4/21-4/22	◆ HIV Testing Procedures (Two days)
2/10-2/11	Mental Health Services (Two days)
2/18-2/20	Reducing the Risk and Harm of HIV (Three days)
3/3, 6/2	◆ Introduction to Case Management (One day) (For COBRA case management)
3/10, 6/9	◆ Enhancing the Partnership Between Client and Case Manager (One day)
3/12, 5/14[c]	HIV/AIDS Update (3 hours)
3/12, 5/14[c]	Promoting Adherence to HIV Treatment (3 hours)
3/17	◆ Cultural Diversity Training for Case Managers (One day)
3/24-3/25	Serving Families: From Assessment to Service Plan (1½ days)
4/7[a]	HIV & STDs (3 hours)
4/23[b]	HIV Treatment Fraud (3 hours)
4/23[b]	◆ Reducing Perinatal Transmission in Prenatal, Maternity and Newborn Settings (3 hours)
4/28	◆ Domestic Violence in Lesbian, Gay, Bisexual and Transgender Communities (One day)
5/5-5/8	◆ Community HIV/AIDS Educator Training (Four days)

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

◆ *Training courses are provided under NYS OASAS Education and Provider Certificate Number 0305 and are acceptable for meeting CASAC/CPP/CPS education and training requirements.*

For a complete listing of Year 2003 courses, the curriculum of Special Request courses, CDUHR-sponsored 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.

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

Statistics and Data Analysis Core
Shiela M. Strauss, Ph.D.

Strategic National and International Comparisons Core
Don C. Des Jarlais, Ph.D. (Director, Chemical Dependency Institute, Beth Israel Medical Center)

Training and Dissemination Core
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CDUHR 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)
NDRI Co-Investigator: Don Des C. Jarlais, Ph.D.
PI: T. Hammett, Ph.D.

Drug Use and HIV Risk in Nicaragua (NIDA)
Principal Investigator: Michele G. Shedlin, 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.

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 HIV/AIDS Knowledge Among the Deaf (NIMH)
Principal Investigator: Marjorie F. Goldstein, 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.

New Hispanic Immigrants and HIV Risk (NICHD)
Principal Investigator: Michele G. Shedlin, 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.