

# CDUHR news

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

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An important advance in our ability to track the epidemic in the U.S. has been achieved now that all states are reporting HIV infections.

## Trends in HIV Infection in the U.S. and N.Y.C.

In 2004, Georgia became the last state in the U.S. to begin reporting HIV infections to the Centers for Disease Control and Prevention (CDC).<sup>1</sup> For many years, only AIDS cases were reported nationally. However, using AIDS surveillance data to determine trends was problematic since, without treatment, it took an average of 10 years for HIV infection to progress to AIDS. Thus, AIDS case data provided HIV infection trends that were approximately 10 years old. With the advent of highly active antiretroviral therapy (HAART), which slows the progression of HIV, and uneven access to treatment for persons infected with HIV, determining transmission patterns solely through AIDS surveillance became even more difficult. Since the HIV/AIDS epidemic undergoes continuous change, having complete nationwide data on reported HIV infections is critical in providing up-to-date information on trends in the U.S.

The CDC analyzed HIV trends, from 1999-2002, in 29 states that conducted names-based reporting.<sup>2</sup> These results, summarized below, should be viewed with caution since the report does not include data for New York, California and Texas—three of the top four states in AIDS cases—these states began HIV reporting in 2000, 2002 and 1999 respectively. Although these 29 states only account for an estimated 35% of AIDS cases in the U.S. (based on cumulative AIDS cases through 2002)<sup>3</sup> the data may provide some indication of trends in the epidemic.

### Trends in the 29 States (1999–2002)

In the 29 states, 102,590 were diagnosed with HIV, 70.5% were male, 29.5% were female. Among men, 60% were MSM, 18% were infected through heterosexual contact and 16% through injection drug use; 49% were African-American. Among women, 77% were infected through heterosexual contact and 20% through injection drug use; 72% of the women were African-American. Africans-Americans accounted for

the majority (55%) of all infections. The 35-44 age category accounted for 36% of the infections, followed by the 25-34 age group (29%).<sup>2</sup>

**Race/Ethnicity**—While African-Americans accounted for the majority of HIV infections, there were no significant changes in reporting trends between 1999-2002. During this period, there was a 26% and 8% increase among Hispanics and Whites, respectively.<sup>2</sup>

### Risk categories

**Men who have sex with men (MSM)**—The largest increase in reporting was seen among MSM, where the number of new diagnoses increased by 17%.<sup>2</sup>

**Injection drug use (IDU)**—The number of IDU-related HIV infections did not change significantly between 1999-2002.<sup>2</sup> (Note: since the CDC report does not include most states with the highest rankings of MSM and IDU AIDS cases, these results should be viewed with particular caution).<sup>4</sup>

**HIV diagnoses concurrent with AIDS diagnoses**—The number of individuals receiving an HIV diagnosis at the same time as an AIDS diagnosis did not change significantly during this period.<sup>2</sup> In 2001, it is estimated that 40% were diagnosed with AIDS within 12 months of being diagnosed with HIV<sup>5</sup> (an indication of being diagnosed in the later stages of the disease).

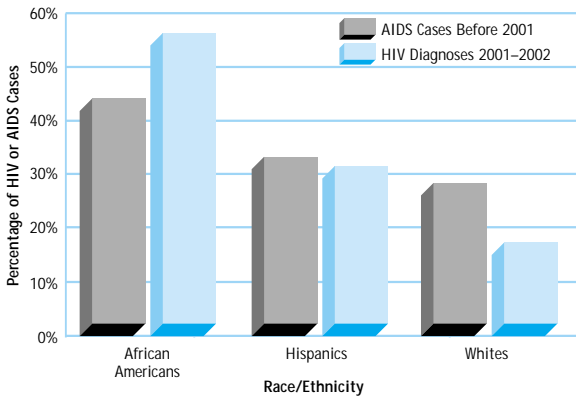
### New York City HIV Infection: 2001-2002

New York City accounts for approximately 14% of persons living with AIDS and 17% of AIDS-related deaths in the U.S.<sup>6</sup> The NYC AIDS epidemic among IDUs has been one of the largest and oldest in the world, and much can be learned from the NYC experience—about how epidemics change over time and how prevention efforts can affect HIV prevalence and incidence rates.<sup>7</sup> Thus, a brief review of recent data on HIV infection in NYC follows.

Among HIV cases diagnosed in 2001 and 2002, 66% were among men, 34% were among women. African-Americans accounted for 54% of infections,

*(Continued next page.)*

## HIV Diagnoses in 2001–2002 and Cumulative AIDS Cases through December 2000, NYC: Comparison by Race/Ethnicity



followed by Hispanics (29%), and Whites (15%).<sup>6,8</sup> African-Americans accounted for 42% of those diagnosed with AIDS in NYC prior to 2001, followed by Hispanics (31%) and Whites (26%).<sup>9</sup> This suggests a shift in the epidemic towards African-Americans.

The largest proportion of reported HIV infections was among those 30-39 (36%), followed by the those 40-49 (29%). In the transmission risk categories, 43% were in the unknown or still under investigation category, thus accurate estimates of risk categories are, at this time, difficult to determine. Overall, approximately 26% of those diagnosed with HIV were also diagnosed with AIDS at the same time. African-Americans were the most likely to receive a concurrent AIDS diagnosis

with an HIV diagnosis, followed by Hispanics and Whites (28%, 25%, 22% respectively).<sup>6,10</sup>

### Summary

There are many disturbing findings among these data on HIV infection in NYC and in the subset of 29 states in the U.S.: the continuing disproportionate number of Africans-Americans and Hispanics among HIV cases, the rising number of new HIV diagnoses among MSM, and the high number of individuals diagnosed in the later stages of the disease. In addition, it is estimated that 25% of those living with HIV are unaware they are infected because they have never been tested.<sup>2,6</sup>

An important advance in our ability to track the epidemic in the U.S. has been achieved now that all states are reporting HIV infections. This will permit identification of trends in the epidemic including changes in geographic regions, risk categories and race/ethnic groups, so that it can be determined where new or continuing prevention and treatment efforts are needed.

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4. CDC AIDS cases by state and metropolitan area of residence, 2000. HIV/AIDS surveillance supplemental report. Volume 8, Issue 2. Atlanta, GA: CDC.
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6. NYC Department of Health and Mental Hygiene. (2004, January). HIV epidemiology program: 1st quarter report. Volume 2, Number 1.
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## NEW CDUHR PROJECT

*In this section of the newsletter, information regarding a newly funded research project is described.*



### An Intervention for Migrant Puerto Rican Drug Users: The Bienvenidos Project (NIDA)

Principal Investigator: Sherry Deren, Ph.D.

A recently completed study (Puerto Rican Drug Users in NY and PR: HIV Risk Behavior Determinants; ARIBBA II, S. Deren, PI) found that among Puerto Rican IDUs in New York, those who migrated from Puerto Rico reported higher levels of risky injection behavior (e.g., shooting gallery use and sharing injection equipment). The Bienvenidos Project is a continuation of the ARIBBA project. It is developing and evaluating an intervention that incorporates peer outreach workers and program

staff from methadone maintenance treatment programs (MMTPs). Using a group randomized trial design, the study will be based in four pairs of MMTPs in Manhattan, Brooklyn, the Bronx and Newark, NJ. Within each pair of MMTPs, one will be assigned to the intervention, which will provide joint training of staff and peer outreach workers regarding the higher level of risk behaviors among Puerto Rican migrant drug users, and train peers in outreach and risk reduction among migrants. In the comparison programs, peers will receive a non-HIV related training. Study outcomes to be assessed include changes in clinic services to address the needs of migrants, and reductions in drug- and sex-related risk behaviors of peers and migrants.

“HIV rates and behaviors vary widely by location. Where you live in the U.S. is a much better predictor of your odds of being an HIV-positive IDU than is needle sharing. This project helps lay the foundation for structural interventions to prevent HIV epidemics among IDUs.”

Samuel R. Friedman, Ph.D.,  
Principal Investigator

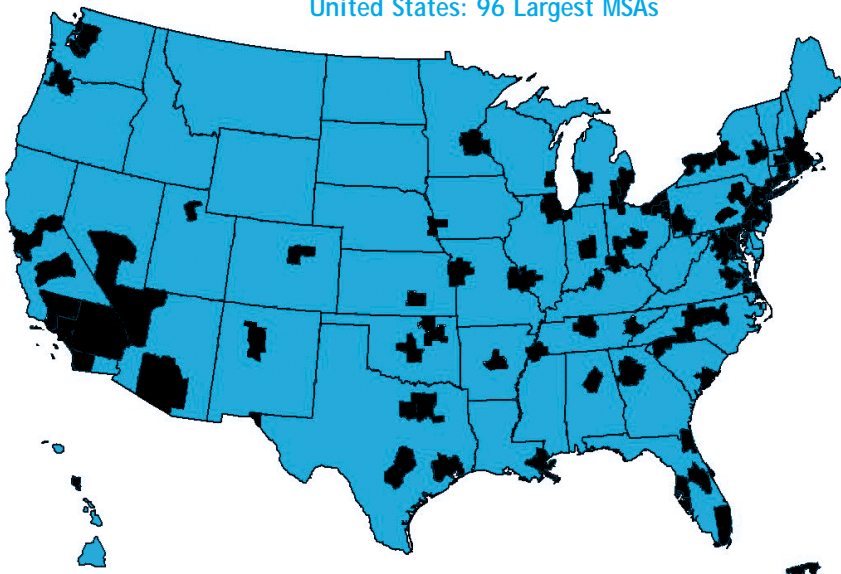
## Community Vulnerability and Responses to IDU-Related HIV

Principal Investigator: Samuel R. Friedman, Ph.D.  
Funding Agency: NIDA

### Background and Objectives

The current project builds on a 1996 study by Holmberg which estimated the prevalence and incidence of HIV in the 96 largest metropolitan areas (MSAs) in the U.S., in the early 1990s.<sup>1</sup> In order to track the epidemic in each of the MSAs, the size of the population in three main transmission categories was estimated: injection drug users (IDUs), men who have sex with men (MSM), and men and women at high risk from heterosexual activity. Estimates were based on data from three major sources: 1) specific studies on these groups regarding HIV prevalence and incidence; 2) reported AIDS cases from STD clinics, HIV counseling and testing sites, drug treatment centers and other sources of population testing; and 3) local and state health department estimates, impressions and unpublished data. The current study focuses on the IDU-related HIV/AIDS epidemic and is using additional data sources and new methodologies to arrive at current HIV prevalence estimates, estimates of the number of IDUs, and availability of drug treatment, syringe exchange and HIV testing and counseling for IDUs in the 96 MSAs.

United States: 96 Largest MSAs



The objectives of the study are to:

- Describe the HIV/AIDS epidemic among IDUs, and the state of drug treatment, syringe exchange and outreach programs in each of the 96 MSAs
- Determine socioeconomic, policy or other characteristics that are related to higher proportions of IDUs in the population and higher HIV prevalence rates among IDUs
- Determine metropolitan area characteristics that are related to public health responses (e.g., outreach to IDUs, syringe exchange programs [SEPs] and drug treatment programs)

### Methods

Datasets have been obtained from multiple sources including: Holmberg’s estimates on IDUs, the National Household Survey on Drug Abuse (NHSDA), Uniform Crime Reports, the National Drug and Alcoholism Treatment Unit Survey, the Uniform Facility Data Set (UFDS), U.S. Census data on poverty, population and residential segregation, CDC AIDS case data, and Beth Israel Medical Center’s survey data on SEPs. In addition, a survey of “Community Experts” was conducted to provide current information on prevention efforts in selected MSAs.

### Findings

*Estimates of the number of IDUs*—The national total number of IDUs is estimated at 1,364,874 past-year injectors in 1998, compared to Holmberg’s estimate of 1,460,300 past-year injectors from the early 1990s.<sup>2</sup> The estimated number of IDUs ranged from 19 to 173 per 10,000 among the 96 MSAs (median 60), in 1998. The highest rate of IDUs per 10,000 was in Fresno (173), followed by Baltimore (162), Stockton-Lodi (149), San Francisco (146), Tucson (139), Bakersfield (128), New York (125), Fort Worth-Arlington (114), Las Vegas (107) and Springfield (107). Among community experts, 143 provided feedback on estimates from 80 MSAs. Approximately 81% of the local experts agreed with the estimates for their localities. Of the remaining, 8% thought the estimates were too low and 11% thought they were too high.<sup>2</sup> *(Continued next page.)*

*Availability of drug treatment and HIV counseling and testing*—On average, it is estimated that MSAs provide drug treatment to approximately 10% of IDUs; HIV counseling and testing is provided to approximately 9% of IDUs.



(Top): Marie Keem, M.Ed., Senior Research Associate, Samuel R. Friedman, Ph.D., Principal Investigator, Hannah Cooper, Sc.D., Post-Doctoral Fellow (Bottom): Risa Friedman, M.P.H., Senior Research Associate, Barbara Tempalski, M.A., M.P.H., ABD, Project Director

There is, however, considerable variability across MSAs. The top quarter of MSAs provide drug treatment to 14%-39% of IDUs, while the bottom quarter provides treatment to less than 5% of IDUs. Disparities are also evident regarding the availability of HIV counseling and testing—the top quarter provides this service to 13%-19% of IDUs, and the bottom quarter provides it to less than 5% of IDUs.<sup>2</sup>

*Laws on syringe access*—Analysis of HIV prevalence (in the early 1990s) in the 96 MSAs with laws prohibiting over-the-counter sale or sale of syringes without prescriptions (anti-OTC syringe laws) showed that 36 had anti-OTC syringe laws.<sup>3</sup> In a comparison between MSAs with and without such laws, the average HIV prevalence rate was almost 14% for areas with anti-OTC syringe laws versus 7% for areas without such laws.<sup>3</sup>

*Characteristics related to the establishment of SEPs*—Factors associated with having SEPs included total population in the MSA and MSAs with larger populations of MSM. In addition, the presence of an

ACT UP chapter in the MSA also was strongly associated with the presence of a SEP. However, need (measured by HIV prevalence and incidence among IDUs, AIDS cases among IDUs and the proportion of IDUs in the MSA) was not associated with having an SEP.<sup>4</sup>

### Limitations, Implications and Recommendations

Despite the extensive efforts undertaken to accurately estimate the number of IDUs in the 96 MSAs, there may be some limitations in the data, methodology and calculations used to obtain these estimates. Unfortunately, there is little information available to validate the results. Although it is possible that the estimates do not reflect the actual number of IDUs in specific MSAs, it is likely that the comparative rates are accurate. In addition, there are also limitations in comparing MSAs with anti-OTC syringe laws to those without such laws, since syringe access may be affected by a number of factors unrelated to the law. While acknowledging some of the limitations, there is evidence the estimates are valid. The significant decline shown in the national total of IDUs, from the early 1990s to 1998, is consistent with evidence that many drug users delayed, avoided or shifted from injection use to other modes of administration.<sup>2</sup>

An earlier study on 77 MSAs showed that income inequality and poverty are associated with higher rates of drug injection.<sup>5</sup> Along with results presented here, they suggest that policy and political factors affect the number of IDUs, as well as HIV prevalence and incidence. Additional analyses will be conducted to further explore the relationship of these and other factors, as well as longitudinal analyses to look at changes within MSAs. These data and results will be made available to policy makers, program staff, user activists and researchers to encourage their utilization and to promote further research.

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For additional information on this study you may contact Sam Friedman, Ph.D., Principal Investigator - E-mail: sam.friedman@ndri.org

“Drug treatment programs are uniquely situated to provide hepatitis C (HCV) services to their clients.”

Shiela M. Strauss, Ph.D.,  
Principal Investigator

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## HCV Service Innovations in Drug Treatment Programs

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

### Background and Objectives

It is estimated that over 4 million individuals in the U.S. have been infected with the hepatitis C virus (HCV).<sup>1</sup> With an estimated prevalence of 60-90% among injection drug users (IDUs), and many other drug users infected with the virus, HCV is currently the most common blood-borne infection among those who use drugs. The majority of infections become chronic, and over a period of 20-30 years, liver cancer, cirrhosis or liver failure develops in approximately 20% of those infected. Despite its high prevalence among drug users, many are unaware of their HCV status and are also uninformed about prevention and treatment options. Drug treatment programs are in a unique position to provide HCV services to drug users, who are generally medically underserved, and a difficult-to-reach population. However, there has been almost no systematically collected information on the HCV-related services provided by these programs.

The objectives of the study are to:

- Measure the extent to which HCV services (education and counseling, testing, medical care and support) are currently provided by drug treatment programs
- Examine and compare the level of HCV services that the programs provide based on organizational and client characteristics
- Conduct case studies of drug treatment programs in order to understand the process of adopting and developing HCV services and the implementation of HCV service delivery practices and procedures

- Determine the clients' perceptions of HCV services and the service delivery process in the case study sites and compare them with staff perceptions of services



Janetta Astone, Ph.D., Project Director & Shiela M. Strauss, Ph.D., Principal Investigator

### Programs and Methods

From the October 1, 2000 Inventory of Substance Abuse Treatment Services (a comprehensive list of public and private substance abuse treatment programs in the U.S.), a random sample of drug treatment programs were selected for possible inclusion in the study. Criteria for eligibility for the study were: location within the U.S., provides treatment on-site for drug (not only alcohol) abuse and provides drug treatment to at least 50% of its patients. Programs that provide detoxification only, or treatment for less than seven days, were excluded from the study.

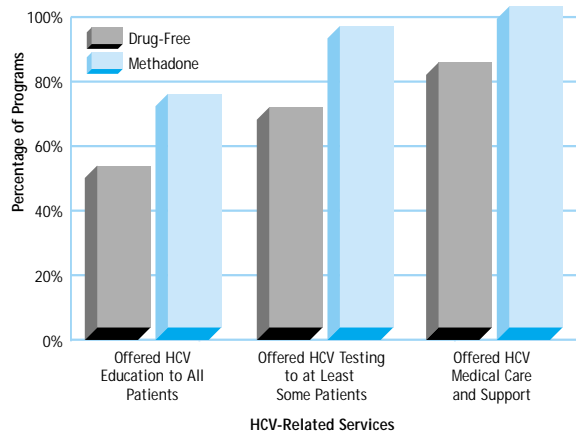
In the first phase of the study, a screening questionnaire was administered on the telephone to program managers to determine eligibility for the study and to obtain information on patient and program characteristics and basic information about HCV services provided. A total of 614 programs were eligible and completed the interviews in this phase. In the second phase, in a smaller sample of eligible programs, three full-length interviews were administered by telephone to program directors, clinical supervisors and medical directors to obtain more comprehensive information on program and patient characteristics and HCV services provided. In total, 291 programs completed at least one part of the interview. In the third phase, case studies were done on-site in 11 programs throughout the U.S. Interviews were conducted with patients and staff to determine experiences and satisfaction with services, suggestions on how to improve services and the perception on how well these services were being implemented.

### Findings to Date

*HCV education services*—In a sample of 434 programs, 236 (54%) offered HCV education to all their patients, while 198 (46%) did not. Programs were more likely to educate all patients when: they were residential (vs. outpatient programs), dispensed methadone, provided HCV education for their staff and provided HIV testing on site.<sup>2</sup> In a comparison between 152 drug-free and 94 methadone programs that offered some HCV education, the two modalities differed on some of the specific topics covered: for example, how to avoid becoming infected (85% vs. 94% respectively) or transmit HCV (85% vs. 97%), how to maintain (Continued next page.)

health if HCV-positive (70% vs. 92%), what to do if co-infected with HIV (63% vs. 81%) and treatment options (75% vs. 88%). For both types of programs, only 57% covered the importance of vaccinations for hepatitis A and hepatitis B, if HCV-positive. In general, methadone programs offered more comprehensive education than drug-free programs.<sup>3</sup>

**HCV-Related Services Offered to Patients in Drug-Free and Methadone Maintenance Treatment Programs**



**HCV testing services**—In a sample of 256 programs (161 drug-free, 95 methadone), 198 (77%) offered HCV testing to at least some of their patients. Methadone programs were significantly more likely to offer testing than drug-free programs (94% vs. 68%). In the programs that did not offer testing, the most frequently cited reason was lack of resources, either financial or personnel. Among programs that offered HCV testing, only 76% of methadone programs and 44% of drug-free programs offered testing for all patients. However, even among programs that offered testing for all patients, only 62% of patients provided specimens for testing.<sup>4</sup>

**HCV medical care and support**—In programs where the staff were aware of at least one HCV-positive patient, most (82%) of the drug-free programs offered medical support, either on site or by referral, but virtually all of the methadone programs (99.5%)

offered such support. Methadone programs were also more likely than drug-free programs to: refer patients for treatment, offer counseling by the clinical staff, advocate for HCV-positive patients with providers, and provide support groups and case management for HCV-positive patients.<sup>5</sup>

**Case study findings**—In-depth case studies were conducted at 11 residential, outpatient and methadone maintenance drug treatment programs throughout the country. All of the programs provided at least some patients with HCV services. Program staff and clients perceived a number of barriers to the adoption and implementation of HCV-related services at their programs, including: 1) competing program priorities and staff time constraints; 2) lack of funding for creating or expanding HCV-specific services; 3) gaps in community HCV resources and referral options; 4) patients' psychosocial issues, such as denial, fear and disease stigma; and 5) the need to improve staff members' HCV-related awareness, knowledge and counseling skills. Many staff and patients were particularly concerned about the lack of consistent and comprehensive availability of HCV primary prevention education for all patients within their programs.<sup>6</sup>

**Implications and Recommendations**

The results from this study demonstrate that there are many gaps in HCV-related services provided by drug treatment programs. Almost half of all programs do not offer HCV education to all patients and there is a high level of dissatisfaction among program managers with the current level of services provided. While some programs are planning to begin offering HCV testing, others are planning to reduce these services due to a lack of funding.<sup>4</sup> The case study research has also identified many misconceptions about HCV among both patients and staff. Drug treatment programs need to better inform all their patients about HCV risks and prevention, and provide their staff with the latest information on HCV.

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

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# 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 August–December 2004, offered at no cost. All courses are held at the NDRI main offices unless otherwise noted.

Date	Course	Date	Course
8/2, 10/18	◆ Introduction to Case Management (One day) (For COBRA case management)	9/28, 11/1 <sup>a</sup>	What's New in HIV/AIDS? (3 hours)
8/3	HIV Disclosure (3 hours)	10/6 <sup>c</sup>	◆ Cultural Diversity Training for Case Managers (One day)
8/3, 9/28, 11/1 <sup>a</sup>	◆ Overview of HIV Infection and AIDS (3 hours)	10/8, 12/6 <sup>d</sup>	HIV/AIDS Confidentiality Law (3 hours)
8/9, 10/25	◆ Enhancing the Partnership Between Client and Case Manager (One day)	10/12-10/14, 12/7-12/9	Reducing the Risk and Harm of HIV (Three days)
8/12 <sup>b</sup> , 10/20 <sup>a</sup>	◆ Implementing Rapid HIV Testing (4 hours)	10/27	◆ Basic Information About Domestic Violence (One day)
8/16-8/17, 11/9-11/10	Serving Families: From Assessment to Service Plan (1½ days)	11/3-11/4	◆ HIV Testing Procedures (Two days)
9/9	Tailoring HIV Counseling and Testing to the Unique Needs of Adolescents (One day)	11/29-12/1	Skills Practice and Implementation of Stage-Based Behavioral Counseling (Three Days)
9/13-9/16	◆ Community HIV/AIDS Educator Training (4 days)		

<sup>a</sup> Lincoln Hospital, Bronx  
<sup>b</sup> Project Samaritan, Queens  
<sup>c</sup> Bronx AIDS Services  
<sup>d</sup> Woodhull Hospital, Brooklyn

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

For a complete listing of 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) 845-4550. 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

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International Research Core  
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Addressing Health Disparities in HIV/AIDS Clinical Trials (NIAID)  
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*PI: D. Mildvan, M.D.*

Applying Web Technology to Buprenorphine Treatment (NIDA)  
*PI: Lisa A. Marsch, Ph.D.*

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

Community Vulnerability and Responses to IDU-Related HIV (NIDA)  
*PI: Samuel R. Friedman, Ph.D.*

Computer-Assisted HIV Prevention for Young Drug Users (NIDA)  
*PI: Lisa A. Marsch, Ph.D.*

Contextual Influences on Sexual Risk among Latino MSM (NICHD)  
*CDUHR Co-I: Michele G. Shedlin, Ph.D.*  
*PI: M.C. Zea, Ph.D.*

Couples HIV Intervention Randomized Controlled Trial (NIDA)  
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Cross-Border HIV Prevention Project: China and Vietnam (NIDA)  
*CDUHR Co-I: Don C. Des Jarlais, Ph.D.*  
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Drug Use and HIV Risk in Nicaragua (NIDA)  
*PI: Michele G. Shedlin, Ph.D.*

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

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

HCV Service Innovations in Drug Treatment Programs (NIDA)  
*PI: Shiela M. Strauss, Ph.D. (ITSR)*

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

An Intervention for Migrant Puerto Rican Drug Users (NIDA)  
*PI: Sherry Deren, Ph.D.*

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

Measuring HIV/AIDS Knowledge Among the Deaf (NIMH)  
*PI: Marjorie F. Goldstein, Ph.D.*

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

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

Networks, Norms, and HIV/STI Risk Among Youth (NIDA)  
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UAB-NDRI-Substance Abuse ICOHRTA in Ukraine (NIDA)  
*CDUHR Co-Directors: Sherry Deren, Ph.D. and Samuel R. Friedman, Ph.D.*  
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WHO Survey Coordinating Center, Drug Injecting Study—Phase 2 (WHO)  
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Women Drug Users, Their Male Partners and HIV Risk (NIDA)  
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