aspects of what works in prevention, including standards for programs, evaluation methodologies, cost effectiveness, the role of cultural specificity and targeting of interventions, and addressing ways to encourage better two-way communications between those who staff or administer prevention programs and behavioral scientists. The likely focus for seared-year (1995) activities will be "the policy impediments continuing to vex effective HIV prevention... identifying what those policy impediments are, what progress had been made on them over the past 10 years, and what strategies might be **pursued to** push forward on them over the next decade" (4).

CONCLUSIONS

Behavioral research, a crucial component of recommended HIV/AIDS prevention policy, is vulnerable to influences from outside the research community, because its application often involves humanconduct over which segments of our society have conflicting values, beliefs, and opinions. If a commitment to behavioral science-based HIV prevention of the scope and redirection called for by the CDC Advisory Committee on the Prevention of HIV and others is to be initiated, much less achieved, then there needs to be leadership, flexibility, and new partnership arrangements.

The difficulty in implementing and sustaining a long-term, substantial behavioral science-based approach to HIV/AIDS prevention is succinctly summed up by the Advisory Committee's call for "generational changes in social norms." But this will be possible not only through sustained and substantial funding, but also through program flexibility that allows for true experimentation in behavioral approaches. This means a difficult period ahead. Past HIV prevention efforts have been characterized by: charges of micromanaging by Congress; detailed directives from the funding agencies which at the same time have not taken enough risks through support of strong and targeted behavioral interventions; unrealistic expectations; and many community-based activities that are so localized and dispersed as to be unevaluable and unaccountable.

Congressional and Executive Branch leadership in resetting the HIV/AIDS prevention agenda is critical. Actions to be considered by Congress include: a broader approach to prevention, concentrating on outcomes rather than on specific programs and activities; federal agencies' roles and funding in basic and applied behavioral research and the interrelationships between these federal agencies; and the relative roles and finding of behavioral and biomedical approaches to the HIV/AIDS epidemic. One long-time observer of national AIDS/HIV policy summarizes his view of Congress's role as follows: "I think Congress (beyond its general oversight responsibilities to make sure the programs are really working as intended) should limit its role to perhaps requiring of the CDC and/or the Public Health Service, a prevention plan to accompany its budget request along the scale of that now required of the NIH for AIDS research. This would be a way to assure Congress that prevention spending is based on a systematic review of the science, of existing programs, of the epidemiology, and of community needs" (10).

Leaders in the Executive Branch-at a minimum, the Secretary of DHHS, the Assistant Secretary for Health, and the Director of the CDC-must set the tone and challenge for their agencies' efforts to elevate HIV prevention activities to a significantly higher plane of attention and resources, and to improve the behavioral science base of these activities. An immediate indication of this commitment to a long-term strategy for HIV prevention will be the report of the DHHS HIV/AIDS Coordinating Committee and its subsequent use in influencing Executive Branch HIV/AIDS policies.

Flexibility of PHS agencies' responses will also be critical. As the Advisory Committee stated, "(u)nfortunately, the structure of (its) review precluded an analysis of CDC's *overall* approach to HIV prevention: the plan, the objectives, the acceptable outcomes, the components of the prevention mix that are (and are not) achieving success. Such an analysis is a logical-and necessary-next step" (l). The CDC's October 1994 response to the Advisory Committee's findings and recommendations should include its response to the Advisory committee's query as to whether CDC's organizational structure may be hindering prevention efforts. Subsequent queries should also inquire into the continued viability of CDC's five program strategies (strengthen current systems, increase public understanding, implement school health education programs, collaborate with prevention partners, and increase knowledge of HIV serostatus), as the HIV prevention efforts are clearly entering a Phase IV, and CDC previously had changed its program strategies with each new phase.

Finally, a clear message of the Advisory Committee's report is the need for new partnership arrangements between the finding agencies and community-based governmental and nongovernmental organizations, and the CDC has responded quickly with community-based planning in its cooperative Agreements. However, much more technical assistance is needed by both health departments and community-based organizations if their preventive activities are to "be **guided** by science." Moreover, CDC's operating paradigm is the classical public health model, not behavioral health, so it must forge closer alliances with behavioral science agencies and researchers.

In this second decade of the HIV/AIDS epidemic, there are both opportunities and a necessity for a substantially larger effort in, and transformation toward, behavioral science-based methods of HIV prevention. The External Review of the CDC's Advisory Committee on the Prevention of HIV Infection has been a catalyst for this potential turning point, and widespread participation in its review process has raised expectations of a major shift in emphasis. The extent of such a commitment and its proposed strategies, are about to be unveiled.