EDITORIAL

A Comprehensive HIV Prevention Program

It has been 10 years since the first cases of an illness, subsequently defined as acquired immunodeficiency syndrome (AIDS), were reported by health care providers in California and the Centers for Disease Control (CDC). Since then, the AIDS epidemic has expanded in scope and magnitude as the human immunodeficiency virus (HIV) infection has affected different populations and geographic areas.

As we move into the 1990s, the nations of the world must reflect on this epidemic, assess their progress in prevention, and affirm their course for this coming decade. CDC, the nation's disease prevention agency, must assess the knowledge and experiences we have gained in meeting the challenge of the HIV epidemic during the 1980s. This issue of *Public Health Reports* focuses on CDC's HIV prevention efforts.

In a *Public Health Reports* article published earlier this year (*1*), I described CDC's overall HIV prevention strategy. This issue describes the programs CDC has funded to carry out that strategy. CDC has collaborated with numerous public and private institutions that are contributing to HIV prevention efforts. Successful prevention of HIV transmission requires individual effort as well as the collective participation of national, State, and local governmental and nongovernmental organizations. Building prevention capacities represents part of our commitment to make HIV prevention a practical reality. We need leadership and commitment from all sectors of society if we are going to prevent the further spread of HIV infection. There is no room for complacency in the 1990s; program needs can be expected to grow at a pace that will likely strain available resources.

The methods that ultimately prove to be the most successful in countering the HIV epidemic may be those that parallel methods used to help reduce cigarette smoking. We are evolving into a nation in which not smoking is the accepted social norm. We have used various strategies to come this far in achieving this feat, although it has taken nearly 40 years to achieve that objective. Lessons learned in the antismoking effort certainly can assist us in accomplishing our important HIV prevention objectives.

The United States has set formal HIV prevention objectives for the next 10 years in the document "Healthy People 2000: National Health Promotion and Disease Prevention Objectives" *(2)*. The objectives are challenging, and much must be accomplished to achieve these goals (see accompanying box). In this regard, there will be debates over the resources required to meet the needs for HIV research, treatment and services, and prevention. We must find the right balance among these three needs. For now, prevention is our best weapon against this lethal infection.

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References

1. Roper, W. L.: Current approaches to prevention of HIV infections. Public Health Rep 106: 111-115, March-April 1991.
2. Public Health Service: Healthy people 2000: national health promotion and disease prevention objectives. DHHS Publication No. (PHS) 91-50212, Office of the Assistant Secretary for Health, Office of Disease Prevention and Health Promotion. U.S. Government Printing Office, Washington, DC, 1990.

18. HIV Infection

Health Status Objectives

18.1 Confine annual incidence of diagnosed AIDS cases to no more than 98,000 cases. (Baseline: An estimated 44,000 to 50,000 diagnosed cases in 1989.)

Special population targets

Diagnosed AIDS cases		*1989 Baseline*	*2000 Target*
18.1a	Gay and bisexual men	26,000–28,000	48,000
18.1b	Blacks	14,000–15,000	37,000
18.1c	Hispanics	7,000–8,000	18,000

Note: Targets for this objective are equal to upper bound estimates of the incidence of diagnosed AIDS cases projected for 1993.

18.2 Confine the prevalence of HIV infection to no more than 800 per 100,000 people. (Baseline: An estimated 400 per 100,000 in 1989.)

Special population targets

Estimated prevalence of HIV infection (per 100,000)		*1989 Baseline*	*2000 Target*
18.2a	Homosexual men	[1]2,000–42,000	20,000
18.2b	Intravenous drug abusers	[2]30,000–40,000	40,000
18.2c	Women giving birth to live-born infants	150	100

[1]Per 100,000 homosexual men aged 15 through 24 based on men tested in selected sexually transmitted disease clinics in unlinked surveys; most studies find HIV prevalence of between 2,000 and 21,000 per 100,000.
[2]Per 100,000 intravenous drug abusers aged 15 through 24 in the New York City vicinity; in areas other than major metropolitan centers, infection rates in people entering selected drug treatment programs tested in unlinked surveys are often under 500 per 100,000.

Risk Reduction Objectives

18.3* Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17. (Baseline: 27 percent of girls and 33 percent of boys by age 15; 50 percent of girls and 66 percent of boys by age 17; reported in 1988.)

18.4* Increase to at least 50 percent the proportion of sexually active, unmarried people who used a condom at last sexual intercourse. (Baseline: 19 percent of sexually active, unmarried women aged 15 through 44 reported that their partners used a condom at last sexual intercourse in 1988.)

Special population targets

Use of condoms		*1988 Baseline*	*2000 Target*
18.4a	Sexually active young women aged 15–19 (by their partners)	26 percent	60 percent
18.4b	Sexually active young men aged 15–19	57 percent	75 percent
18.4c	Intravenous drug abusers	. . .	60 percent

Note: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens who are not yet sexually active.

18.5 Increase to at least 50 percent the estimated proportion of all intravenous drug abusers who are in drug abuse treatment programs. (Baseline: An estimated 11 percent of opiate abusers were in treatment in 1989.)

18.6 Increase to at least 50 percent the estimated proportion of intravenous drug abusers not in treatment who use only uncontaminated drug paraphernalia ("works"). (Baseline: 25 to 35 percent of opiate abusers in 1989.)

18.7 Reduce to no more than 1 per 250,000 units of blood and blood components the risk of transfusion-transmitted HIV infection. (Baseline: 1 per 40,000 to 150,000 units in 1989.)

Services and Protection Objectives

18.8 Increase to at least 80 percent the proportion of HIV-infected people who have been tested for HIV infection. (Baseline: An estimated 15 percent of approximately 1 million HIV-infected people had been tested at publicly funded clinics in 1989.)

18.9* Increase to at least 75 percent the proportion of primary care and mental health care providers who provide age-appropriate counseling on the prevention of HIV and other sexually transmitted diseases. (Baseline: 10 percent of physicians reported that they regularly assessed the sexual behaviors of their patients in 1987.)

Special population target

Counseling on HIV and STD prevention		*1987 Baseline*	*2000 Target*
18.9a	Providers practicing in high incidence areas	...	90 percent

Note: Primary care providers include physicians, nurses, nurse practitioners, and physician assis-

tants. Areas of high AIDS and sexually transmitted disease incidence are cities and States with incidence rates of AIDS cases, HIV seroprevalence, gonorrhea, or syphilis that are at least 25 percent above the national average.

18.10 Increase to at least 95 percent the proportion of schools that have age-appropriate HIV education curricula for students in 4th through 12th grade, preferably as part of quality school health education. (Baseline: 66 percent of school districts required HIV education but only 5 percent required HIV education in each year for 7th through 12th grade in 1989.)
Note: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens who are not yet sexually active.

18.11 Provide HIV education for students and staff in at least 90 percent of colleges and universities. (Baseline data available in 1995.)

18.12 Increase to at least 90 percent the proportion of cities with populations over 100,000 that have outreach programs to contact drug abusers (particularly intravenous drug abusers) to deliver HIV risk reduction messages. (Baseline data available in 1995.)
Note: HIV risk reduction messages include messages about reducing or eliminating drug use, entering drug treatment, disinfection of injection equipment if still injecting drugs, and safer sex practices.

18.13* Increase to at least 5O percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that screen, diagnose, treat, counsel, and provide (or refer for) partner notification services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia). (Baseline: 40 percent of family planning clinics for bacterial sexually transmitted diseases in 1989.)

18.14 Extend to all facilities where workers are at risk for occupational transmission of HIV regulations to protect workers from exposure to bloodborne infections, including HIV infection. (Baseline data available in 1992.)
Note: The Occupational Safety and Health Administration (OSHA) is expected to issue regulations requiring worker protection from exposure to bloodborne infections, including HIV, during 1991. Implementation of the OSHA regulations would satisfy this objective.

NOTE: Duplicate objectives, which appear in two or more priority areas, are marked with an asterisk (*).

SOURCE: Healthy People 2000: National Health Promotion and Disease Prevention Objectives. DHHS Publication (PHS) 91-50213. Office of the Assistant Secretary for Health, Office of Disease Prevention and Health Promotion. U.S. Government Printing Office, Washington, DC, 1990, pp. 119–120.