EDITORIAL NOTES

Reflections on AIDS: Lessons for the Future

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On June 4, 1981, a report of five cases of *Pneumocystis carinii* pneumonia (PCP) in homosexual men in Los Angeles appeared in CDC's *Morbidity and Mortality Weekly Report* (MMWR), representing the first publication about acquired immunodeficiency syndrome (AIDS). Within 1 month, additional reports of PCP, other fatal opportunistic infections and a rare cancer (Kaposi's sarcoma) were reported among gay men in New York as well as California.

Thanks to a highly specific case definition (which was adopted worldwide) and strong support from local health departments and concerned physicians, it was established that the syndrome was new and increasing rapidly. By the end of 1982, the epidemiologic patterns strongly suggested that AIDS was caused by an agent that could be transmitted sexually between men and between men and women and transmitted by blood among injecting drug-users and recipients of blood and blood products. Cases were also identified among infants born to women with AIDS. It was also clear that AIDS cases represented only the "tip of the iceberg" of an epidemic with persons in high-risk populations noting an increased frequency of generalized lymphadenopathy, idiopathic thrombocytopenia, lymphomas and other conditions.

Though the virus causing AIDS was not yet discovered, in 1983 the U.S. Public Health Service issued recommendations to prevent transmission of AIDS through sexual contact and blood donation. Within the next year, isolation of the causal virus (now known as HIV) facilitated development of assays to diagnose the infection and protect the blood supply. Very unfortunately, HIV proved to be a chronic infection with lifelong persistence and variable but inexorable progression. As it does in individuals, so also in communities and countries, HIV precedes AIDS by many years, causing an insidious epidemic of suffering and death. It is estimated that more than 250,000 Americans had already been infected with HIV by the time of the June 1981 report of five cases of PCP.

In the decades following the early 1980s, advances in monitoring and treating patients with HIV have greatly lengthened and improved the quality of life for hundreds of thousands of persons with HIV, mostly in high-income countries. In these same countries, perinatal transmission of HIV has been reduced by over 80%. Despite this scientific progress, HIV remains incurable and no vaccine has been proven effective.

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Meanwhile, HIV has progressed to infect over 60 million, now becoming the world's fourth leading cause of death. The global impact of AIDS has yet to peak with estimates of new infections still exceeding deaths by millions per year. Despite recent impressive donor commitments in the world, the vast majority of persons with HIV are unaware of their own infection status and have little or no access to lifesaving therapy.

Some lessons from the past can guide us in preventing HIV and providing care for those infected in both the United States and throughout the world.

First, we must beware of complacency and of the tendency to underestimate the power of HIV to spread among vulnerable populations—especially adolescents and young adults in all nations. Continued education and motivation will be needed to overcome individual and community ignorance and denial.

Second, HIV and its modes of transmission will continue to bear stigma, which fosters shame, secrecy and mistrust. Effective HIV prevention and care approaches need to see this as a barrier and attempt to overcome it.

Third, successful leaders will build consensus around science-based approaches to HIV prevention. Concerns about saving lives must overcome political and religious differences in dealing with scientifically proven approaches to prevention such as condom availability and adequately funded programs for injecting drug users (including treatment and needle-and-syringe exchanges).

Fourth, successful partnerships from the past must be re-energized. When most effective, persons with HIV and other advocates, government officials and caregivers worked together to combat the epidemic. This fosters trust and can assure that HIV treatment and prevention are linked and both receive attention.

Fifth, HIV/AIDS and behavioral risk factor surveillance approaches need re-vamping in the era of effective HIV therapy. In the 1980's, AIDS surveillance and mortality was highly accurate, and frequent reports were the "conscience" of the epidemic in the United States and the world. Twenty first century surveillance of HIV and risk behaviors must closely monitor the epidemic and risk behaviors while continuing to address privacy concerns.

Sixth, resources committed to science for vaccines, therapies and other tools must be enhanced and continued.

Finally, the global HIV epidemic demands a global response—with expertise and resources shared with populations in greatest need. We must work together to decrease suffering and death due to AIDS and stop the spread of HIV infection.