Chapter 5: HIV Prevention Strategies in Medical Care Settings

2 Contact Hours

Learning objectives

- Name and distinguish between the ways HIV can and cannot be spread.
- List the precautions recommended by the CDC to prevent transmission of HIV to health care personnel in the workplace.
- List the factors affecting risk for transmission of HIV in general and among health care workers in particular.
- Identify three primary groups of people who require education on HIV.
- Identify population targets for HIV testing.
- Define and describe the Centers for Disease Control and Prevention’s new initiative.
- List four key strategies for the Centers for Disease Control and Prevention’s new initiative.

Preventing occupational HIV transmission to health care personnel [1]

The human immunodeficiency virus (HIV) is not spread easily. You can only get HIV if you get infected blood or sexual fluids into your system. You can’t get it from mosquito bites, coughing or sneezing, sharing household items or swimming in the same pool as someone with HIV.

Some people talk about “shared body fluids” being risky for HIV, but no documented cases of HIV have been caused by sweat, saliva or tears. However, even small amounts of blood in your mouth might transmit HIV during kissing or oral sex. Blood can come from flossing your teeth, or from sores caused by gum disease, or by eating very hot or sharp, pointed food.

To infect someone, the virus has to get past the body’s defenses. These include skin and saliva. If your skin is not broken or cut, it protects you against infection from blood or sexual fluids. Saliva contains chemicals that can help kill HIV in your mouth.

If HIV-infected blood or sexual fluid gets inside your body, you can get infected. This can happen through an open sore or wound, during sexual activity, or if you share equipment to inject drugs.

HIV can also be spread from a mother to her child during pregnancy or delivery. This is called “vertical transmission.” A baby can also be infected by drinking an infected woman’s breast milk. Adults exposed to breast milk of an HIV-infected woman may also be exposed to HIV.

Health care personnel and exposure [12]

An exposure that might place health care personnel at risk for HIV infection is defined as a percutaneous injury (e.g., a needle stick or cut with a sharp object) or contact of mucous membrane or nonintact skin (e.g., exposed skin that is chapped, abraded, or afflicted with dermatitis) with blood, tissue or other body fluids that are potentially infectious. In addition to blood and visibly bloody body fluids, semen and vaginal secretions also are considered potentially infectious. Although semen and vaginal secretions have been implicated in the sexual transmission of HIV, they have not been implicated in occupational transmission from patients to health care personnel.

The following fluids also are considered potentially infectious: cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid and amniotic fluid. The risk for transmission of HIV infection from these fluids is unknown; the potential risk to health care personnel from occupational exposures has not been assessed by epidemiologic studies in health care settings. Feces, nasal secretions, saliva, sputum, sweat, tears, urine and vomitus are not considered potentially infectious unless they are visibly bloody; the risk for transmission of HIV infection from these fluids and materials is low.

Any direct contact (i.e., contact without barrier protection) to concentrated virus in a research laboratory or production facility requires clinical evaluation. For human bites, clinical evaluation must include the possibility that both the person bitten and the person who inflicted the bite were exposed to blood-borne pathogens. Transmission of HIV infection by this route has been reported rarely, but not after an occupational exposure.

Preventive strategies [7]

To prevent transmission of HIV to health care personnel in the workplace, the Centers for Disease Control and Prevention (CDC) offers the following recommendations. Health care personnel should assume that the blood and other body fluids from all patients are potentially infectious, so they should follow infection control precautions at all times.

These precautions include:

- The routine use of barriers (such as gloves and/or goggles) when anticipating contact with blood or body fluids.
- Washing hands and other skin surfaces immediately after contact with blood or body fluids.
- The careful handling and disposing of sharp instruments during and after use.

Safety devices have been developed to help prevent needle-stick injuries. If used properly, these types of devices may reduce the risk of exposure to HIV. Many percutaneous injuries are related to sharps disposal. Strategies for safer disposal, including safer design of disposal containers and placement of containers, are being developed.

Although the most important strategy for reducing the risk of occupational HIV transmission is to prevent occupational exposures, plans for postexposure management of health care personnel should be in place. CDC has issued guidelines for the management of health care personnel exposures to HIV and recommendations for postexposure prophylaxis (PEP): Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis (June 29, 2001).
Risk for occupational transmission of HIV [12]

The risks for occupational transmission of HIV vary with the type and severity of exposure. In prospective studies of health care personnel, the average risk for HIV transmission after a percutaneous exposure to HIV-infected blood has been estimated to be approximately 0.3 percent (95 percent confidence interval [CI] = 0.2 percent–0.5 percent) and after a mucous membrane exposure, approximately 0.09 percent (CI = 0.006 percent–0.5 percent). Although episodes of HIV transmission after nonintact skin exposure have been documented, the average risk for transmission by this route has not been precisely quantified but is estimated to be less than the risk for mucous membrane exposures. The risk for transmission after exposure to fluids or tissues other than HIV-infected blood also has not been quantified but is probably considerably lower than for blood exposures. Epidemiologic and laboratory studies suggest that multiple factors might affect the risk for HIV transmission after an occupational exposure.

In a retrospective case-control study of health care personnel who had percutaneous exposure to HIV, increased risk for HIV infection was associated with exposure to a larger quantity of blood from the source person as indicated by:

- A device (e.g., a needle) visibly contaminated with the patient’s blood.
- A procedure that involved a needle being placed directly in a vein or artery.
- A deep injury. The risk also was increased for exposure to blood from source persons with terminal illness, possibly reflecting either the higher titer of HIV in blood late in the course of acquired immunodeficiency syndrome (AIDS) or other factors (e.g., the presence of syncytia-inducing strains of HIV).

A laboratory study that demonstrated that more blood is transferred by deeper injuries and hollow-bore needles lends further support for the observed variation in risk related to blood quantity. The use of source-person viral load as a surrogate measure of viral titer for assessing transmission risk has not yet been established. Plasma viral load (e.g., HIV RNA) reflects only the level of cell-free virus in the peripheral blood; latently infected cells might transmit infection in the absence of viremia. Although a lower viral load (e.g., less than 1,500 RNA copies/ml) or one that is below the limits of detection probably indicates a lower titer exposure, it does not rule out the possibility of transmission.

HIV prevention in medical care settings [7]

Despite significant advances in the treatment of HIV infection, the estimated number of annual new HIV infections in the United States has remained at 40,000 for nearly 10 years[16]. Historically, HIV prevention in this country has generally focused on persons who are not HIV-infected, to help them avoid becoming infected. However, further reduction of HIV transmission will require new strategies, including an increased emphasis on preventing transmission by HIV-infected persons aware of their status [26,28]. This may be a highly cost-effective strategy in that prevention is targeted directly to potential sources of new infections.

After testing positive for HIV, many people reduce behaviors that may transmit HIV to others [2, 38]. However, recent studies suggest that such behavioral changes are not maintained by all HIV-infected persons and that some continue to engage in behaviors that place others at risk for HIV infection [5, 21].

Routine HIV prevention programs and support are needed to help HIV-infected persons reduce behavioral risks and maintain safer behavior in the years after the diagnosis of HIV infection. Studies have tested interventions in this population and have demonstrated significant reductions in risky sexual and drug-use behaviors. For example, in a study at public HIV clinics of HIV-infected persons who had multiple sex partners at baseline, the prevalence of unprotected anal and vaginal intercourse was reduced 38 percent after brief, ongoing prevention counseling from primary care providers [8, 35]. Successful risk-reduction interventions for HIV-infected persons have also been conducted in group settings [12]. Further, interventions for HIV-infected persons who inject illicit drugs have reduced illicit drug use and unsafe sex in this population [30, 36]. A number of studies have demonstrated the beneficial effect of substance abuse treatment, particularly methadone maintenance treatment, on HIV-risk behaviors among injection drug users (IDUs) [25]. Taken as a whole, the findings strongly suggest that a concerted, sustained effort to provide prevention counseling and appropriate referral to services can greatly benefit HIV-infected persons and help them maintain safer behaviors that prevent others from becoming infected with HIV. However, recent studies suggest the need for targeted health care personnel training on the importance of HIV transmission prevention counseling [23].

HIV and AIDS in America: Today [22]

HIV and AIDS affect all sectors of American society – men and women, young and old, black and white, gay and straight, rich and poor. The impact of AIDS has nevertheless been more serious among some groups than others. In the early years of the epidemic, the most commonly identified “vulnerable groups” in America were men who have sex with men, injecting drug users, hemophiliacs and Haitians.

Today, AIDS continues to infect thousands of gay and bisexual men and injecting drugs users every year, but it has also become a serious problem among heterosexual African Americans, and the Latino population is increasingly affected, too.

Prevention [22]

On a national scale, the main HIV prevention strategy in America is to introduce widespread HIV testing to identify HIV-positive people. The Advancing HIV Prevention (AHP) initiative, for example, advocated voluntary testing in all health care facilities as well as improved partner notification services to ensure partners of HIV-positive people were made aware of the risk they were at. More recently, the U.S. has also implemented new testing guidelines that state that all adolescents and adults aged 15–64 should be routinely tested for HIV whenever they visit a health care facility [15].

Beyond AHP, the U.S. has no other national prevention strategy or prevention targets. Prevention initiatives that actively work to prevent people from becoming infected tend to be carried out on a state- or citywide level, either by local authorities or by HIV support organizations. Such prevention initiatives may concentrate on particular communities or groups of people, or they may be more general in their focus. Independent organizations play a particularly big role in preventing HIV among injecting drug users, as it is illegal for federal money (and occasionally state or city money) to be used for needle exchange programs.

One area where prevention efforts have been successful in the U.S. is the prevention of mother-to-child transmission (PMTCT). Routine HIV testing for pregnant women in many states, and good treatment
and care, means that diagnoses of HIV in babies have dropped dramatically since HIV was first discovered in the US.

![AIDS cases in the USA, 1981-2005](image)

In other areas, prevention efforts have had less of an effect, however, and while combination anti-retroviral treatment has helped to dramatically reduce the number of people developing and dying of AIDS in America overall, about 40,000 continue to be diagnosed with AIDS every year (see the graph). This suggests that HIV infection levels are not declining.

In September 2007, over 100 AIDS organizations joined together to call for the introduction of a national AIDS strategy that would set out a clear national prevention plan and bring an end to the 40,000 new infections that occur each year [32]. The campaign targeted the candidates for the 2008 presidential election, a number of whom had a particular interest in HIV and AIDS.

“The wealthiest nation in the world is failing its own people in responding to the AIDS epidemic at home. Our country must develop what it asks of other nations it supports in combating AIDS: a comprehensive national strategy to achieve improved and more equitable results,” said Rebecca Haag, executive director of AIDS Action [33].

### AIDS and sex education [22]

The level and type of sex and HIV/AIDS education received by school children and students tends to vary depending on state regulations and the type of school or college a child is attending. In some areas, sex education that incorporates information on HIV is comprehensive and compulsory. In others, it is not, and children may leave school knowing virtually nothing about HIV and AIDS.

In recent years, abstinence-only education, which was backed by former President George Bush and teaches children to wait until marriage before having sex, has become particularly popular. However, this form of sex education has proved controversial, as many say it is ineffective and does not adequately teach about sexually transmitted infections and other related issues [31]. Many AIDS and sexual health organizations therefore advocate a more comprehensive approach that includes information about condoms and general discussion of teenage sexual relationships.

AIDS education among adults is also used as a prevention tool, particularly in communities where HIV levels are high. Discussion of AIDS in the workplace or at community meetings and religious gatherings can provide essential information to adults whom might otherwise be unaware they are at risk.

### Education of the infected patient [3]

When people talk about AIDS education, they usually have in mind education that is provided to people who are not yet infected with HIV – often young people – to help them stay uninfected. While this is clearly important, it is also vital that people who are already living with HIV receive AIDS education.

### Why educate HIV-positive people? [3]

HIV-positive people need HIV/AIDS education to provide help and support for them, enabling them to understand and to cope with the knowledge that they are infected with HIV. Education for HIV-positive people should also help to prevent the onward transmission of HIV.

When receiving an HIV-positive test result, many people feel that they have been given a death sentence. HIV/AIDS education and counseling for HIV-positive people has several main goals:

- To help people to cope with the trauma of an HIV-positive test result.
- To inform HIV-positive people about the nature of HIV and AIDS.
- To help them to confront any discrimination they may face as a result of being infected with HIV.
- To enable them to lead full and healthy lives.
- To enable them, should they wish, to have an active sexual life without passing the infection on to anyone else.
- To ensure that the infection isn’t passed on by any other means – the sharing of injecting equipment, for example.

Most people who are HIV-positive have acquired the infection from another person, whether sexually or via injecting equipment. Just as people who are not HIV-positive must take responsibility for their own protection, so must people who are HIV-positive take responsibility for ensuring that they do not pass the virus on to anyone else.

### What do HIV-positive people need to know? [3]

HIV does not discriminate. While some groups have been more affected than others, people across all sectors of society are affected by HIV. This means that some HIV-positive people will have little more in common than the fact that they are HIV-positive. Beyond their health care requirements, they will have very different needs and will need different types of support, services and education. A person who tests HIV-positive, for example, may need advice on how to cope with discrimination at work, while another may need support and help to stop injecting drugs, and yet another advice on how to get a mortgage.

People who are HIV-positive need to know the basic facts about their condition:

- They need to know the difference between HIV and AIDS, and to be informed about both. In spite of the HIV/AIDS education done in the past, misconceptions still exist. An HIV-positive test result can be very distressing, and many people feel that they have been given a death sentence. People in this situation need to know whether their HIV infection has progressed to AIDS and that being infected with HIV does not necessarily mean that a person has AIDS. It can take many years for people with HIV to develop AIDS.
- People need to know what happens next, what tests they will need to have, and what the results mean. Depending on these test results, patients can be told whether they need to take any medication.
● They need to know that they may have to change their behavior. Partaking in the same activities that caused them to become infected could infect another person in the same way. They could also put themselves at risk of becoming infected with additional sexually transmitted infections, which could increase the progression of their HIV infection towards an AIDS diagnosis.

● People also need to be informed about the type of lifestyle that could help to keep them healthy. They need to know that their body will require good nutrition, if possible, in order to fight infection. They need to know that smoking, drug and alcohol abuse can weaken the body’s immune system, making them more prone to opportunistic infections.

● Education needs to focus on how to insist on safer sex. Many HIV-positive people around the world, especially women, may not fully be in control of how they express themselves sexually.

● Safer sex must be practiced with other HIV-positive people, too. There’s an attitude of “if we’re both HIV-positive, it doesn’t matter.” This isn’t the case, as there are different strains of HIV, some of which have become resistant to some of the drugs used to treat AIDS.

● They need to know about their rights in society and what to do in the event that they experience harassment or discrimination.

● They will also want to know what they can expect from the medical care available in their country, if they will be able to access AIDS medication, and if so, how to go about it. In some countries, the health service or medical insurance may provide medications; in other places, people may have to attempt to be accepted onto clinical trials as the only way of accessing medicines.

HIV-positive people who are informed are better equipped to decide whether they will let people know about their HIV status, and better equipped to challenge discrimination and stigmatization.

Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health care [15]

Adults and adolescents

CDC recommends that diagnostic HIV testing and opt-out HIV screening be a part of routine clinical care in all health care settings while also preserving the patient’s option to decline HIV testing and ensuring a provider-patient relationship conducive to optimal clinical and preventive care. The recommendations are intended for providers in all health care settings, including hospital EDs, urgent-care clinics, inpatient services, STD clinics or other venues offering clinical STD services, tuberculosis (TB) clinics, substance abuse treatment clinics, other public health clinics, community clinics, correctional health care facilities, and primary care settings. The guidelines address HIV testing in health care settings only; they do not modify existing guidelines concerning HIV counseling, testing and referral for persons at high risk for HIV who seek or receive HIV testing in nonclinical settings (e.g., community-based organizations, outreach settings, or mobile vans) [6].

Screening for HIV infection

● In all health care settings, screening for HIV infection should be performed routinely for all patients ages 13-64. Health care providers should initiate screening unless prevalence of undiagnosed HIV infection in their patients has been documented to be less than 0.1 percent. In the absence of existing data for HIV prevalence, health care providers should initiate voluntary HIV screening until they establish that the diagnostic yield is less than 1 per 1,000 patients screened, at which point such screening is no longer warranted.

● All patients initiating treatment for TB should be screened routinely for HIV infection [13].

● All patients seeking treatment for STDs, including all patients attending STD clinics, should be screened routinely for HIV during each visit for a new complaint, regardless of whether the patient is known or suspected to have specific behavior risks for HIV infection.

Repeat screening

● Health care providers should subsequently test all persons likely to be at high risk for HIV at least annually. Persons likely to be at high risk include injection-drug users and their sex partners, persons who exchange sex for money or drugs, sex partners of HIV-infected persons, and men who have sex with men or heterosexual persons who themselves or whose sex partners have had more than one sex partner since their most recent HIV test.

● Repeat screening of persons not likely to be at high risk for HIV should be performed on the basis of clinical judgment.

● Health care providers should encourage patients and their prospective sex partners to be tested before initiating a new sexual relationship.

● Unless recent HIV test results are immediately available, any person whose blood or body fluid is the source of an occupational exposure for a health care provider should be informed of the incident and tested for HIV infection at the time the exposure occurs.

Consent and pretest information

● Screening should be voluntary and undertaken only with the patient’s knowledge and understanding that HIV testing is planned.

● Patients should be informed orally or in writing that HIV testing will be performed unless they decline (opt-out screening). Oral or written information should include an explanation of HIV infection and the meanings of positive and negative test results, and the patient should be offered an opportunity to ask questions and to decline testing. With such notification, consent for HIV screening should be incorporated into the patient’s general informed consent for medical care on the same basis as are other screening or diagnostic tests; a separate consent form for HIV testing is not recommended.

● Easily understood informational materials should be made available in the languages of the commonly encountered populations within the service area. The competence of interpreters and bilingual staff to provide language assistance to patients with limited English proficiency must be ensured.

● If a patient declines an HIV test, this decision should be documented in the medical record.
Diagnostic testing for HIV infection

- All patients with signs or symptoms consistent with HIV infection or an opportunistic illness characteristic of AIDS should be tested for HIV.
- Clinicians should maintain a high level of suspicion for acute HIV infection in all patients who have a compatible clinical syndrome and who report recent high-risk behavior. When acute retroviral syndrome is a possibility, a plasma RNA test should be used in conjunction with an HIV antibody test to diagnose acute HIV infection [37].
- Patients or persons responsible for the patient’s care should be notified orally that testing is planned, advised of the indication for testing and the implications of positive and negative test results, and offered an opportunity to ask questions and to decline testing. With such notification, the patient’s general consent for medical care is considered sufficient for diagnostic HIV testing.

Recommendations for pregnant women

These guidelines reiterate the recommendation for universal HIV screening early in pregnancy but advise simplifying the screening process to maximize opportunities for women to learn their HIV status during pregnancy, preserving the woman’s option to decline HIV testing, and ensuring a provider-patient relationship conducive to optimal clinical and preventive care. All women should receive HIV screening consistent with the recommendations for adults and adolescents. HIV screening should be a routine component of preconception care, maximizing opportunities for all women to know their HIV status before conception [14]. In addition, screening early in pregnancy enables HIV-infected women and their infants to benefit from appropriate and timely interventions (e.g., anti-retroviral medications [20], scheduled cesarean delivery [27], and avoidance of breastfeeding [40]). These recommendations are intended for clinicians who provide care to pregnant women and newborns and for health policy makers who have responsibility for these populations.

HIV screening for pregnant women and their infants [9]

Universal opt-out screening

- All pregnant women in the United States should be screened for HIV infection.
- Screening should occur after a woman is notified that HIV screening is recommended for all pregnant patients and that she will receive an HIV test as part of the routine panel of prenatal tests unless she declines (opt-out screening).
- HIV testing must be voluntary and free from coercion. No woman should be tested without her knowledge.
- Pregnant women should receive oral or written information that includes an explanation of HIV infection, a description of interventions that can reduce HIV transmission from mother to infant, and the meanings of positive and negative test results and should be offered an opportunity to ask questions and to decline testing.
- No additional process or written documentation of informed consent beyond what is required for other routine prenatal tests should be required for HIV testing.
- If a patient declines an HIV test, this decision should be documented in the medical record.

Addressing reasons for declining testing

- Providers should discuss and address reasons for declining an HIV test (e.g., lack of perceived risk; fear of the disease; and concerns regarding partner violence or potential stigma or discrimination).
- Women who decline an HIV test because they have had a previous negative test result should be informed of the importance of retesting during each pregnancy.
- Logistical reasons for not testing (e.g., scheduling) should be resolved.
- Certain women who initially decline an HIV test might accept at a later date, especially if their concerns are discussed. Certain women will continue to decline testing, and their decisions should be respected and documented in the medical record.

Timing of HIV testing

- To promote informed and timely therapeutic decisions, health care providers should test women for HIV as early as possible during each pregnancy. Women who decline the test early in prenatal care should be encouraged to be tested at a subsequent visit.
- A second HIV test during the third trimester, preferably at least 36 weeks of gestation, is cost-effective even in areas of low HIV prevalence and may be considered for all pregnant women. A second HIV test during the third trimester is recommended for women who meet one or more of the following criteria.
  - Women who receive health care in facilities in which prenatal screening identifies at least one HIV-infected pregnant woman per 1,000 women screened.
  - Women who are known to be at high risk for acquiring HIV (e.g., injection-drug users and their sex partners, women who exchange sex for money or drugs, women who are sex partners of HIV-infected persons, and women who have had a new or more than one sex partner during this pregnancy).
- Women who have signs or symptoms consistent with acute HIV infection. When acute retroviral syndrome is a possibility, a plasma RNA test should be used in conjunction with an HIV antibody test to diagnose acute HIV infection [37].
Rapid testing during labor

- Any woman with undocumented HIV status at the time of labor should be screened with a rapid HIV test unless she declines (opt-out screening).
- Reasons for declining a rapid test should be explored (see addressing reasons for declining testing).
- Immediate initiation of appropriate anti-retroviral prophylaxis [27] should be recommended to women on the basis of a reactive rapid test result without waiting for the result of a confirmatory test.

Postpartum/newborn testing

- When a woman’s HIV status is still unknown at the time of delivery, she should be screened immediately postpartum with a rapid HIV test unless she declines (opt-out screening).
- When the mother’s HIV status is unknown postpartum, rapid testing of the newborn as soon as possible after birth is recommended so anti-retroviral prophylaxis can be offered to HIV-exposed infants. Women should be informed that identifying HIV antibodies in the newborn indicates that the mother is infected.
- For infants whose HIV exposure status is unknown and who are in foster care, the person legally authorized to provide consent should be informed that rapid HIV testing is recommended for infants whose biologic mothers have not been tested.
- The benefits of neonatal anti-retroviral prophylaxis are best realized when it is initiated less than 12 hours after birth [39].

Confirmatory testing

- Whenever possible, uncertainties regarding laboratory test results indicating HIV infection status should be resolved before final decisions are made regarding reproductive options, anti-retroviral therapy, cesarean delivery, or other interventions.
- If the confirmatory test result is not available before delivery, immediate initiation of appropriate anti-retroviral prophylaxis [27] should be recommended to any pregnant patient whose HIV screening test result is reactive to reduce the risk for perinatal transmission.

Advancing HIV prevention [9]

In 2003, the Centers for Disease Control and Prevention’s new initiative, Advancing HIV Prevention: New Strategies for a Changing Epidemic, was aimed at reducing barriers to early diagnosis of HIV infection and, if positive, increasing access to quality medical care, treatment and ongoing prevention services. The initiative emphasizes the use of proven public health approaches to reduce the incidence and spread of disease. As with other sexually transmitted diseases (STDs) or any other public health concern, principles applied to prevent disease and its spread will be used, including appropriate routine screening, identification of new cases, partner counseling and referral services, and increased availability of sustained treatment and prevention services for those infected [10].

CDC’s HIV prevention activities over the past two decades have focused on helping uninfected persons at high risk for HIV change and maintain behaviors to keep them uninfected. Despite these efforts, the number of new HIV infections is estimated to have remained stable and the number of persons living with HIV continues to increase.

The initiative capitalizes on new rapid test technologies, interventions that bring persons unaware of their HIV status to HIV testing, and behavioral interventions that provide prevention skills to persons living with HIV.

The next decade promises new hope as three primary areas of HIV prevention are emphasized:

- Early detection of persons who are HIV-positive and referral to care services.
- Prevention interventions with persons living with HIV.
- Prevention with persons who are at high risk for HIV infection.

The initiative consists of four key strategies:

1. Make HIV testing a routine part of medical care. CDC will work with professional medical associations and other partners to ensure that all health care providers include HIV testing, when indicated, as part of routine medical care on the same voluntary basis as other diagnostic and screening tests.

2. Implement new models for diagnosing HIV infections outside medical settings. CDC will fund new demonstration projects using OraQuick®, a rapid HIV test recently approved by the U.S. Food and Drug Administration for use in clinical and non-clinical settings, to increase access to early diagnosis and referral for treatment and prevention services in high-HIV prevalence settings, including correctional facilities.

3. Prevent new infections by working with persons diagnosed with HIV and their partners. CDC in collaboration with the Health Resources and Services Administration (HRSA), the National Institutes of Health, and the HIV Medical Association of the Infectious Diseases Society of America, has published the recommendations for incorporating HIV prevention into the...
medical care of persons with HIV infection. These groups will work to disseminate this document to a variety of health care providers.

4. Further decrease perinatal HIV transmission. CDC will promote recommendations and guidance for routine HIV testing of all pregnant women, and, as a safety net, for the routine screening of any infant whose mother was not screened. CDC will work with prevention partners, including the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Nurse-Midwives, to disseminate the recommendations and support their implementation.

CDC will monitor the implementation of these new activities through several systems, including new performance indicators for state and local health departments and CBOs (community-based organizations) monitoring HIV incidence, and expanding its surveillance system by implementing a national behavioral surveillance system.

Works Cited:


1. “Vertical transmission” is the process by which HIV can be spread from a mother to her child during pregnancy or delivery.
   - True
   - False

2. The potential risk to health care workers from occupational exposures to saliva, sputum, and sweat has been assessed by epidemiologic studies.
   - True
   - False

3. Health care personnel should assume that the blood and other body fluids from all patients are potentially infectious.
   - True
   - False

4. The average risk for transmission by nonintact skin exposure is estimated to be more than the risk for mucous membrane exposures.
   - True
   - False

5. Despite significant advances in the treatment of HIV infection, the estimated number of annual new HIV infections in the United States has remained at 40,000 for nearly 10 years.
   - True
   - False

6. On a national scale, the main HIV prevention strategy in America is to introduce widespread HIV testing to identify HIV-positive people.
   - True
   - False

7. One area where prevention efforts have been successful in the US is the prevention of mother-to-child transmission (PMTCT).
   - True
   - False

8. Patients should not be screened for laboratory evidence of HIV at the initial STD clinic visit.
   - True
   - False

9. When the mother’s HIV status is unknown postpartum, it is useless to test the newborn for HIV.
   - True
   - False

10. Three primary areas of HIV prevention are early detection of persons who are HIV-positive; prevention interventions with persons living with HIV; and prevention with persons who are at high risk for HIV infection.
    - True
    - False