Very specific behaviors and environments perpetuate the spread of human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS) epidemic. Thus, writes the National Commission on AIDS (1993), it is logical that behavioral and social science expertise should be fully utilized in our national and global response to the epidemic, particularly in prevention efforts. However, in sharp contrast to the energetic involvement by behavioral scientists in other health areas such as smoking, safety, and exercise, there has been relatively little activity in HIV prevention by those of us with expertise in behavior change. What are the barriers keeping us so inactive? What can we contribute? How can we accelerate our involvement? This chapter addresses these questions and invites readers to apply the logic and practice of behavioral analysis to the expanding local and global tragedy of AIDS.

At the 1994 Tenth Annual International AIDS Conference, Jonathan M. Mann, the first director of the World Health Organization’s AIDS program, portrayed the global AIDS prevention effort as a failure. Furthermore, he warned that

The gap between the expanding pandemic and the global response is growing, rapidly and dangerously. . . . Pilot projects are not being sustained, the lessons learned from the past global experience are being ignored, commu-
nity and political commitment to AIDS is plateauing or even declining. (Radin, 1994)

At the same conference, grim reports of the exponential spread of the disease into less developed countries (with 4 million people reported, and 17 million estimated as infected worldwide) triggered comparisons with the historical Black Death scourge, which killed 25% of Europeans. Though we knew early in the first AIDS decade that HIV can be kept from spreading by making specific behavioral changes, the alarm call was not given loudly or widely enough. Transmission through contact with infected blood has spread the disease from its earliest epicenters of localized and often marginalized populations, such as communities of gay men, Haitian immigrants, some African groups, and intravenous drug users, via what is predicted to be a massive “second wave” of heterosexual transmission. As AIDS spreads to every continent, it threatens hard-won economic progress in developing countries, further debilitates communities already victimized by poverty and war, and strains all available medical and social resources.

In the United States alone, most recent data from the Centers for Disease Control (1994) tell us that:

- Approximately 1 million people are infected with HIV, representing approximately 1 in 250 Americans.
- Over 300,000 Americans are diagnosed with AIDS.
- The largest reported increase in new AIDS cases is attributed to heterosexual contact among young people.
- AIDS is now the leading cause of death among all Americans 25 to 44 years of age, surpassing homicide, suicide, heart disease, and cancer.

The HIV prevention activities of our nation’s Public Health Service, a division of the US Department of Health and Human Services, include collaboration and assistance with state and local health and education agencies, national and local minority organizations, community-based organizations, academia, business and labor, and religious organizations. Implicit in our national response to HIV is a belief that scientists are relentlessly seeking both a cure and prevention strategies to slow the pace of HIV infection, and that there is a rapid explosion of interest among scientists from many different disciplines (Ostrow & Kessler, 1993).

**SCIENTIFIC ACTIVITY IN AIDS/HIV**

**Psychlit and Medline**

Despite a popular belief that all of our nation’s resources have been brought to bear on the AIDS problem and even a comforting assurance that science is doing its part, the data tell another story on science’s involvement overall, and in prevention activities in particular. One would assume, for in-