

National HIV/AIDS Report United States of America

I. Status at a glance

During 2003-2005, the United States Government (USG) has continued its commitment to turning the tide of the domestic and global HIV/AIDS pandemic.

Domestic epidemic: The United States is categorized as having a concentrated/low-prevalence epidemic. Estimates indicate that between 1,039,000 and 1,185,000 people were living with HIV in the United States in December 2003, of whom 25% were undiagnosed (CDC 2003). HIV continues to have the greatest prevalence among African Americans and men who have sex with men (MSM). At the end of 2003, blacks accounted for 47 percent of people estimated to be living with HIV in the U.S., whites accounted for 34 percent, and Hispanics for 17 percent. By transmission category, MSM remained the most heavily affected group, accounting for 45 percent of people living with HIV. Individuals infected through high-risk heterosexual contact comprised 27 percent, and those infected through injection drug use accounted for 22 percent of the HIV-positive population. Although roughly three-quarters (74%) of Americans estimated to be living with HIV are male, women are increasingly affected by the epidemic (CDC 2005). In response to the domestic epidemic, the United States Congress provides funds to states, metropolitan areas, and local communities through the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act in order to improve the quality and availability of care for low-income, uninsured, and underinsured individuals and families affected by HIV disease. Administered by the Department of Health and Human Services' Health Resources and Services Administration (HRSA), the CARE Act programs provide care to an estimated 571,000 people living with HIV/AIDS in the United States (CDC 2003). The U.S. government is dedicated to improving and modernizing the CARE Act so that new advancements in treatments and medical management can continue to help people with HIV/AIDS live longer and healthier lives.

Global HIV/AIDS pandemic: As a response to the global HIV/AIDS pandemic, in 2003 President Bush announced the President's Emergency Plan for AIDS Relief (PEPFAR), bringing U.S. leadership to the fight against the international HIV/AIDS pandemic. This international health initiative is a 5-year, \$15 billion, multi-faceted initiative active in over 120 countries worldwide. It includes a special focus on 15 severely affected countries, in which its goals include support for: treatment for 2 million HIV-infected people, prevention of 7 million new infections, and care for 10 million people including HIV-infected individuals and orphans and vulnerable children. The Office of the U.S. Global AIDS Coordinator was established in order to develop a single U.S. global HIV/AIDS strategy and coordinate the different U.S. government agencies involved in the global fight. PEPFAR provides support for host nations' efforts to prevent HIV infection, provide high-quality treatment and care for people living with HIV, and build capacity to address their epidemics in an accountable and sustainable way. To cite one example of the results achieved by the USG partnership with host nations, PEPFAR provided support for treatment for over 400,000 people in the 15 focus nations in the first two years of implementation. In addition to bilateral USG programs, PEPFAR includes support for multilateral initiatives. Through PEPFAR, the USG is the largest contributor to the Global Fund

to Fight AIDS, Tuberculosis and Malaria, and provides significant support to other key international partners, such as UNAIDS and the World Health Organization (WHO).

Core indicators for *Declaration of Commitment Implementation*

Generalized Epidemic Indicators

National Commitment and Action

Percentage of schools with teachers who have been trained in life-skills based HIV education and who taught it during the last academic year.

The Centers for Disease Control's (CDC) School Health Policies and Programs Study 2000 provides the following related data:

96.1% of states and 57.3% of districts provided funding for or offered staff development on HIV prevention education to health education teachers.

31.8% of elementary school classes, 39.7% of required health education courses in middle/junior high schools, and 55.6% of required health education courses in senior high schools had a teacher who received staff development on HIV prevention education.

Among teachers of required health education, elementary school teachers who provided HIV prevention education spent a median of 1 hour per school year teaching the topic, middle/junior high school teachers spent a median of 2 hours, and senior high school teachers spent a median of 3 hours.

Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programs.

CDC conducted a national survey of AIDS policies and education programs in the workplace in 1995 as part of its Business Responds to AIDS (BRTA) program. The study included over 2,200 businesses from across the country. One of the major findings of the 1995 study was that the size of the worksite was the most significant characteristic affecting the implementation of any of the 5 BRTA components (workplace policy on HIV/AIDS, supervisor training, employee education, employee family education, and philanthropy and volunteerism). The results were as follows: 40% of small worksites (15-49 employees) implemented some components, 69% of medium-sized worksites (50-749 employees) implemented some components, and 89% of large worksites (750 or more employees) implemented some BRTA components. CDC plans to conduct a follow-up survey within the next year. The results for large worksites were as follows:

Workplace Policy - 80%
Supervisor Training - 78%
Employee Education - 33%
Employee Family Education - 4%
Philanthropy/Volunteerism - 86%

Percentage of women and men with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated, and counseled.

No data.

Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral combination prophylaxis to reduce the risk of mother-to-child transmission.

No data. About 69% of pregnant women in the US in 2002 were reported to have had an HIV test, according to data from CDC's National Center for Health Statistics.

In 2004, there were an estimated 145 infants with perinatal HIV diagnosed in the 35 areas of the United States with confidential name-based HIV infection reporting. This was down from an estimated 306 in 2001, a 52% reduction.

Percentage of women and men with advanced HIV infection receiving antiretroviral combination therapy.

	Persons*	Prescribed HAART at year-end [†]	
		No.	(%)
Year			
2002	13,716	9,443	(69)
2003	3,283	2,301	(70)
Total	16,999	11,744	(69)

HAART = highly active antiretroviral therapy, one of the US-recommended combination antiretroviral protocols.

* Persons with immunological (any CD4 < 200 cell/ μ L) or clinical AIDS (any AIDS-defining opportunistic infection) during the calendar year.

[†] Patients were prescribed HAART during last 6 months of calendar year. This may overestimate the percentage receiving antiretroviral combination therapy at year-end.

Data source: The Adult/Adolescent Spectrum of HIV Disease (ASD) project was a longitudinal cohort study that collected information on health care utilization and HIV disease progression of HIV-infected patients who received care in the United States. Information on the prescription of antiretroviral medicines was collected from periodic review of medical records from 1990-2004. ASD data were collected from selected health-care facilities in California, Colorado, Georgia, Louisiana, Michigan, New York, Puerto Rico, Texas and Washington. Data for this report were collected from patient medical records from 2001 to 2003.

Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child.

No data. Federal CARE Act grantees reported allocating USD 4 million in FY04 on permanency planning and \$5.2 million on child care.

Percentage of transfused blood units screened for HIV.

The Food and Drug Administration (FDA) requires that all blood for transfusion be tested for HIV-1 and HIV-2 with a limited exception for certain autologous (collection and re-infusion of the donor's own blood) donations. It is estimated that 100% of transfused blood units are screened for HIV.

Knowledge and Behavior

Percentage of young women and men aged 15-24 who both correctly identify the ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

No data. 87.9% of students in grades 9-12 have ever been taught about AIDS or HIV infection in school (CDC Youth Behavior Risk Survey 2003).

Percentage of young women and men who have had sex before the age of 15.

Females—13.0% had sex before the age of 15 in 2002
Males—14.6% had sex before age of 15 in 2002

Data Source: Teenagers in the United States: Sexual Activity Contraceptive Use, and Childbearing, 2002. Centers for Disease Control and Prevention, National Center for Health Statistics, Vital and Health Statistics, Series 23, Number 24, December 2004. Table 3. Cumulative percent of never-married males and females 15-19 years of age who have ever had sexual intercourse before reaching selected ages, by age, race, and Hispanic origin: United States, 1988, 1995, and 2002.

Percentage of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months.

Among females aged 15-24 who were unmarried and not cohabiting, 50.7 percent had sexual intercourse in the 12 months before the interview.

Among males aged 15-24 who were unmarried and not cohabiting, 52.7 percent had sexual intercourse in the 12 months before the interview.

Data Source: CDC National Survey of Family Growth, Cycle 6 conducted in 2002.

Percentage of young women and men aged 15 to 24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner.

Among females aged 15-24 who were unmarried and not cohabiting, and had sexual intercourse in the 12 months before the interview, 52.4 percent reported condom use at last sexual intercourse.

Among males aged 15-24 who were unmarried and not cohabiting, and had sexual intercourse in the 12 months before the interview, 68 percent reported condom use at last sexual intercourse.

Data Source: CDC National Survey of Family Growth, Cycle 6, conducted in 2002.

Ratio of current school attendance among orphans to that among non-orphans, aged 1- to 14.

No data.

Impact

Percentage of young women and men aged 15 to 24 who are HIV infected (Target: 24% in most affected countries by 2005; 25% reduction globally by 2010.)

A 2004 study of persons living with HIV/AIDS in 35 areas of the U.S. with confidential name-based HIV infection reporting estimated that 17,054 out of 462,792 (3.7%) of individuals living with HIV/AIDS were young men and women aged 15 to 24.

The numbers in this study are point estimates derived from adjustments of reported case counts. The reported case counts are adjusted for reporting delays and for redistribution of cases in persons initially reported without an identified risk factor.

Data Source: HIV/AIDS Surveillance Report 2004, Vol. 16, Table 8: Estimated numbers of persons living with HIV/AIDS, by year and selected characteristics, 2001-2004—35 areas with confidential name-based HIV infection reporting.

Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy.

A.) Minimum Survival Estimate

Year	Persons*	Still prescribed HAART 12 months after initiation of therapy[†]	
		No.	(%)
2001	413	291	(70)
2002	283	201	(71)
Total	696	492	(71)

HAART = highly active antiretroviral therapy, one of the US-recommended combination antiretroviral protocols.

* Persons started on HAART during the calendar year. Including persons who died, stopped therapy, or were lost during the follow-up year.

† Patients who initiated HAART during 2001-2002 and were receiving therapy precisely 12 months later. This may overestimate the percentage receiving antiretroviral combination continuously throughout the initial 12 months.

B.) Maximum Survival Estimate

Year	Persons*	Still prescribed HAART 12 months after initiation of therapy[†]	
		No.	(%)
2001	311	290	(93)
2002	213	199	(93)
Total	524	489	(93)

HAART = highly active antiretroviral therapy, one of the US-recommended combination antiretroviral protocols.

* Persons started on HAART during the calendar year. Includes persons who have died; excludes persons who stopped therapy, or were lost to follow-up

† Patients who initiated HAART during 2001-2002 and were receiving therapy precisely 12 months later. This may overestimate the percentage receiving antiretroviral combination continuously throughout the initial 12 months.

Note: ASD represents a small sample of persons on HAART.

Data source: The Adult/Adolescent Spectrum of HIV Disease project (see previous description).

Percentage of infants born to HIV-infected mothers who are infected. (Target: 20% reduction by 2005; 50% reduction by 2010.)

In 2004, there were an estimated 145 infants with perinatal HIV diagnosed in the 35 areas of the United States with confidential name-based HIV infection reporting. This was down from an estimated 306 in 2001, a 52% reduction.

Data Source: HIV/AIDS Surveillance Report, CDC, Vol. 16, Table 1, Estimated numbers of cases of HIV/AIDS by year of diagnosis and selected characteristics of persons, 2001-2004—35 areas with confidential name-based reporting.

Concentrated/low Epidemic Indicators

National Commitment and Action

Amount of national funds disbursed by governments in low- and middle- income countries

Not applicable.

National Composite Policy Index

See Appendix A.

Percentage (most-at-risk populations) who received HIV testing in the last 12 months and who know the results.

	Total*	HIV tested in the last 12 months and know the result	
		No.	(%)
Population			
High-risk heterosexual adults	1,052	382	(36)
Injection drug users	711	416	(59)
Men who have sex with men	1,056	680	(64)
Total	2,819	1,478	(52)

High-risk heterosexual adults must have had sex with 1 opposite sex partner but had no same sex partners in the last 12 months.0

Injection drug users must have injected a drug in the last 12 months.

Men who have sex with men must have had oral or anal sex with a man in the last 12 months.

*Persons who did not report being infected with HIV.

Data source: The HIV Testing Survey was a cross-sectional, anonymous behavioral survey that involved interviewing persons at high risk for HIV infection conducted periodically in several different states from 1996 to 2002. Participants included men who have sex with men, injection drug users, and sexually-active heterosexuals. The interview consisted of questions about HIV testing history, sex behavior, drug use, and exposure to prevention services. Data for this report are from the 2002 HIV Testing Survey conducted in 10 US states.

Percentage (most-at-risk populations) reached by prevention programs

No data

Behavior and Knowledge

Percentage of (most-at-risk population(s)) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

No data

Percentage of female and male sex workers reporting the use of a condom with their most recent client.

No data.

Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.

	Total*	Used a condom during last anal sex with a male partner	
		No.	(%)
Age			
18 — 24	1873	1103	(59)
≥25	5926	2994	(51)
Total	7799	4097	(53)

*Men who had anal sex with another man in the last 12 months and who did not report being infected with HIV.

Data source: The National HIV Behavioral Surveillance System (NHBS) is CDC’s most comprehensive system for conducting behavioral surveillance among persons at highest risk for HIV infection in the US. The overall strategy for NHBS involves conducting alternating 12 month cycles of surveillance in three different adult (18+ years of age) populations: men who have sex with men, injection drug users, and heterosexual adults at risk for HIV infection. Surveillance is conducted in 25 metropolitan areas which account for approximately 60% of the

AIDS prevalence in the US. The interview used for NHBS includes questions about HIV testing history, sex behavior, drug use, and exposure to prevention services. Data for this report are from the 2004 cycle of NHBS among men who have sex with men which was conducted in 15 metropolitan areas.

Percentage of injecting drug users who have adopted behaviors that reduce transmission of HIV, i.e., who both avoid using non-sterile injecting equipment and use condoms, in the last month (for countries where injecting drug use is an established mode of HIV transmission)

	Total*	Always used condoms and clean injecting equipment in the last 12 months	
		No.	(%)
Age			
18 — 24	50	5	(10)
≥25	488	57	(12)
Sex			
Male	377	43	(11)
Female	161	19	(12)
Total	538	62	(12)

*Injection drug users who injected in the last 12 months and had anal or vaginal sex in the last 12 months and who did not report being infected with HIV.

Data source: 2002 HIV Testing Survey (see previous description).

Impact

Percentage of (most-at-risk population(s)) who are HIV infected

Percentage data not available but see section entitled ‘Overview of the AIDS epidemic’ below.

Global Commitment and Action

Amount of bilateral and multilateral financial flows (commitments and disbursements) for the benefit of low and middle-income countries.

FY04 USD 2,293,069

FY05 USD 2,681,223

II. Overview of the AIDS epidemic

CDC's 2004 *HIV/AIDS Surveillance Report* presents estimated numbers of cases of HIV/AIDS from the 35 areas (33 states, Guam and the U.S. Virgin Islands) with confidential, name-based reporting. From 2003 to 2004, the total number of new HIV/AIDS cases increased slightly from 38,188 to 38,730.

Tables 1 and 2 show the estimated number of most-at risk adults and adolescents diagnosed with HIV/AIDS in 2003 and 2004.

Table 1. Distribution of the estimated number of diagnoses of HIV/AIDS among adults and adolescents by transmission category in 2003

Transmission Category	Estimated # of AIDS Cases, in 2003		
	Male	Female	Total
Male-to-Male Sexual Contact	16,804	-	16,804
Injection Drug Use	4,177	2,252	6,429
Male-to-Male Sexual Contact and Injection Drug Use	1,398	-	1,398
Heterosexual Contact	4,720	8,248	12,968
Other (hemophilia, blood transfusion, perinatal, and risk not reported or not identified)	179	205	384
Total	27,278	10,705	37,983

Table 2. Distribution of the estimated number of diagnoses of HIV/AIDS among adults and adolescents by transmission category in 2004

Transmission Category	Estimated # of AIDS Cases, in 2004		
	Male	Female	Total
Male-to-Male Sexual Contact	18,203	-	18,203
Injection Drug Use	3,828	2,134	5,962
Male-to-Male Sexual Contact and Injection Drug Use	1,372	-	1,372
Heterosexual Contact	4,581	8,102	12,683
Other (hemophilia, blood transfusion, perinatal, and risk not reported or not identified)	161	174	335
Total	28,145	10,410	38,555

Data Source: HIV/AIDS Surveillance Report 2004, Vol. 16. Estimated numbers of cases of HIV/AIDS, by year of diagnosis and selected characteristics of persons, 2001-2004 from 35 areas with confidential name-based HIV infection reporting. Note that these numbers do not represent reported case counts. Rather, these numbers are point estimates, which result from adjustments of reported case counts.

III. National Response to the AIDS epidemic

Prevention

- CDC's HIV Prevention Strategic Plan 2001-2005 ensures that the agency is responsive to the changing epidemic, scientific advances, and new scientific opportunities.
- The CDC's HIV prevention programs are guided by and supportive of a national public health prevention agenda, known as *Healthy People 2010*, which includes specific objectives to reduce HIV/AIDS.
- In 2003, CDC announced the *Advancing HIV Prevention: New Strategies for a Changing Epidemic* (AHP) initiative. AHP initiative is consistent with the goals of CDC's strategic plan and is a concerted effort to identify HIV positive persons who do not know their status. It aims to reduce barriers to early diagnosis of HIV infection and increase access to quality medical care, treatment, and ongoing prevention services for those living with HIV.

Care/Treatment and support

- The CARE Act provided \$2.0 billion in FY 2003 for HIV/AIDS health care and health-related supportive and ancillary services. Funding increased to \$2.1 billion for FY 2004 and FY 2005.
- The *Healthy People 2010* outlines a comprehensive, nationwide health promotion and disease prevention, diagnosis, and early treatment agenda related to HIV/AIDS.
- Table 3 indicates the amount of other HIV/AIDS treatment expenditures for FY 2003-2005 in US dollars.

Table 3. Treatment expenditures (non-RWCA)

	FY 2003	FY 2004	FY 2005
Medicare/Medicaid	7.2 billion	8 billion	8.6 billion
Substance Abuse and Mental Health Services Administration (SAMHSA)	130 million	131 million	130 million
Minority AIDS Initiative	14 million	14 million	15 million
Global AIDS Trust Fund	50 million	75 million	50 million
TOTAL	7.97 billion	9.02 billion	9.38 billion

Knowledge and behavior change

Please see previous responses on knowledge and behavior indicators.

Impact alleviation

People living with HIV/AIDS often experience barriers that inhibit timely entry into and retention in care. The CARE Act provides a broad array of ancillary services that focus on addressing these barriers and supporting primary care entry and retention. Often these services help people living with HIV to stabilize their lives so that they can be adherent with primary care appointments and therapies. Case management, housing and nutritional assistance, emergency financial assistance, client advocacy, psychosocial support services, and substance abuse treatment all have this kind of stabilizing effect. In 2004, these services were provided by the following number of CARE Act-funded providers:

Case Management	1,446
Housing Assistance	570
Nutritional Assistance	1,238
Emergency Financial Assistance	643
Client Advocacy	697
Psychosocial Support	776
Substance Abuse Treatment	564
Mental Health Treatment	943

Transportation services (provided by 952 CARE Act grantees in 2004) also help people get to their primary care appointments.

The Health Resources and Services Administration (HRSA) funded studies by eight CARE Act grantees in FY1998, and it analyzed data from its own multi-site Client Demonstration Project, to investigate whether the receipt of ancillary services was associated with primary care entry and retention. The summaries below highlight study findings associated with particular ancillary services. These findings were published in an *AIDS Care* Supplement, August 2002. Note that programs at two of the sites (in St. Louis and New Orleans) served infants and children with HIV and their mothers.

Case Management. Three of five sites found clients' receipt of case management to be positively associated with entry into primary care for at least some clients, and four sites (of six) found positive associations with retention in care. The New Orleans site (a family-centered program) found that receipt of any case management services was associated with a reduction in emergency room visits. Data from the CARE Act Client Demonstration Project (CDP) showed that case management services were associated with higher rates of primary care entry for clients with mental health and substance abuse problems.

Mental Health Services. Mental health service receipt was positively associated with primary care entry in three of the five sites that assessed this relationship and with primary care retention in four of the six sites that assessed it. The New York study, the only one to use a longitudinal database, found mental health services to have both contemporaneous and lagged effects upon primary care entry. As with other services that can have stabilizing effects upon clients' lives, it may take some time after receipt of services before clients are ready to engage in primary health care.

Substance Abuse Treatment. Three of the five sites found positive associations between receipt of substance abuse treatment and entry into primary care, and four found positive associations with retention in care.

Transportation Assistance. Three of five studies found receipt of transportation to be positively associated with primary care entry; four found it to be positively associated with primary care retention. Even in New York City, where public transportation is cheap and ubiquitous, receipt of transportation services by clients with a documented need for them had a positive, lagged effect upon entry into appropriate primary care.

Housing Assistance. Three of the four sites examining the association of housing assistance with primary care entry found positive relationships, including New York City, which found a positive but lagged effect between receipt of needed housing assistance and entry into appropriate primary care. A positive relationship was also found in the North Carolina study, where more than ¼ of all participants received housing assistance; indeed, housing was the only ancillary service at this study site that had a consistent positive association with primary care entry and retention. Four of five studies—the only exception being the multi-site CDP—found significant associations between receipt of housing assistance and retention in primary care.

Nutrition Services. Four studies investigated food and nutrition services, two of them (Boston and the multi-site CDP study) finding significant associations with primary care for all clients—the CDP with entry into primary care, and the Boston site with retention in primary care (by both the 2 and 4 visits per year standards). In addition, Washington University (in a program serving women, infants, and children with HIV) found that retention in care improved for women receiving food and nutrition services who had unstable housing, parental responsibility, low CD4 counts, and low educational attainment.

IV. Major challenges and actions needed to achieve UNGASS goals/targets

Key Challenges:

1. The number of people living with HIV/AIDS continues to increase with the advent of effective treatment therapies. The estimated number of persons living with AIDS in the United States increased from the end of 1999 through the end of 2003 (Janssen Testimony 2005). When all 50 states and the District of Columbia are considered, CDC estimates that approximately 40,000 persons become infected with HIV each year (CDC 2003). The estimated HIV prevalence in the United States indicates that between 1,039,000 and 1,185,000 people were living with HIV in December 2003 (CDC 2003). In response to the increase in persons living with AIDS, CARE Act programs have received an increase in funding each year and the Administration has proposed policies to improve efficiencies and outcomes.
2. There is an attendant risk of drug resistance to HAART (Public Financing IOM 2004). RWCA funding supports treatment adherence services and NIH continues research in the development of new therapies and treatment regimens for those infected with drug resistant strains of HIV.

3. The demographics of the epidemic are changing, presenting challenges. Whereas HIV was once considered a disease of white men who have sex with men, people of racial and ethnic minority groups now represent the majority of Americans in the categories of new AIDS cases, new HIV cases, people living with AIDS, and AIDS-related deaths (CDC, 2002). President Bush has publicly announced his strong support for improved reauthorization legislation, which better targets RWCA resources to communities, particularly minority communities, where help is most needed.
4. There is increasing incidence of both medical and social co-morbid conditions among people living with HIV/AIDS (Public Financing IOM 2004). Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) programs are addressing the mental health and substance abuse issues among HIV/AIDS population.
5. Providing treatment and care for people living with HIV has become increasingly costly and complex. Combination antiretroviral therapy typically costs \$14,500 per individual per year (CARE Act ADAP data). New drugs that are used if other treatments do not work cost \$20,000 per individual annually (Brown 2003). The USG proposes to increase the efficiencies in CARE Act programs that will maximize the impact of current federal dollars.
6. Improved tracking of the HIV epidemic is needed. In order to achieve the goal of nationwide, high quality HIV data, the Centers for Disease Control and Prevention recommends that all states and territories adopt confidential, name-based surveillance systems to report HIV infections. Currently, only 35 areas (33 states, Guam and the U.S. Virgin Islands) have this type of confidential name-based HIV infection reporting. CDC provides technical assistance to states to improve their surveillance systems. In addition, CDC is working with states to develop a new system for monitoring HIV incidence (new infections) more directly through the use of a testing method that distinguishes recent from longstanding infections (CDC 2005).
7. The shift from acute-care needs to chronic-care needs has not been reflected in the HIV care delivery system (Public Financing IOM 2004). CARE Act programs need to respond to the shift in HIV infection from a terminal illness to a chronic disease.

V. Support required from country's development partners

None.

VI. Monitoring and evaluation environment

The Centers for Disease Control and Prevention (CDC) is responsible for accurately monitoring the HIV/AIDS epidemic in the United States. Each year, the CDC publishes an HIV/AIDS Surveillance Report.

Additional information:

- National investments in HIV/AIDS-related research continue to increase. The National Institute of Health (NIH) supports a comprehensive program of basic, clinical, and behavioral research on HIV infection and its associated opportunistic infections and malignancies that will lead to a better understanding of the basic biology of HIV, the development of effective therapies to treat it, and the design of better interventions to prevent new infections. NIH supports AIDS research in NIH intramural laboratories and at academic and medical institutions in the United States and internationally. NIH represents the largest single public investment in AIDS research worldwide. The total budget for NIH-funded AIDS research increased from \$2.0 billion in fiscal year 2000 to an estimated \$2.9 billion in fiscal year 2005. President Bush's budget for fiscal year 2006 proposes \$2.9 billion for research on HIV/AIDS.
- NIH dedicates significant resources to HIV/AIDS vaccine research; e.g., \$405.1 million for FY 2003, \$452.3 million for FY 2004, and \$507.2 million for FY 2005 (estimated).

Bibliography

- Brown D. 2003, March 14. FDA Approves First in Class of AIDS Drugs; 'Fusion Inhibitor' Will Help People Whose Bodies Resist Current Medications. *The Washington Post*. P. A2.
- Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report*. Vol. 13(2). Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2003.
- Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report, 2003*. Vol. 15. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2004. <http://www.cdc.gov/hiv/stats/hasrlink.htm>
- Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report, 2004*. Vol. 16. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2005. <http://www.cdc.gov/hiv/stats/hasrlink.htm>
- Centers for Disease Control and Prevention. National HIV Prevention Conference. 2005.
- Fleming, P.L.; Wortley, P.M.; Karon, J.M.; DeCock, K.M., and Janssen, R.S. Tracking the HIV Epidemic: Current Issues, Future Challenges. 2000. *American Journal of Public Health*. 90(7): 1037-41.
- Institute of Medicine (IOM). 2004. *Measuring What Matters: Allocation, Planning, and Quality Assessment for the Ryan White CARE Act*.
- Institute of Medicine (IOM). 2004. *Public Financing and Delivery of HIV/AIDS Care*.
- Janssen, Robert S. 2005. Testimony on *Domestic HIV/AIDS Surveillance: Current Trends and Status of HIV Reporting*.
- Kahn J.G., Haile B., Kates J., Chang S. 2001. Health and federal budgetary effects of increasing access to antiretroviral medications for HIV by expanding Medicaid. *American Journal of Public Health* 91(9):1464-73.