I. Status at a Glance

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

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 percent were undiagnosed (Centers for Disease Control and Prevention (CDC) within the U.S. Department of Health and Human Services (HHS), 2003).

HIV continues to have the greatest prevalence in the United States 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 U.S. HIV-positive population. Although roughly three-quarters (74 percent) of Americans estimated to be living with HIV are male, the epidemic is increasingly affecting women (HHS/CDC, 2005).

In response to the domestic epidemic, the United States Congress provides funds to U.S. States, metropolitan areas, and local communities through the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act, to improve the quality and availability of care for low-income, uninsured, and underinsured individuals and families affected by HIV disease. Administered by HHS Health Resources and Services Administration (HRSA), the CARE Act programs provide care to an estimated 571,000 people living who are with HIV/AIDS in the United States (CDC, 2003). The Ryan White HIV/AIDS Treatment Modernization Act of 2006 reflects the U.S. Government's dedication to improving access to life-extending treatment and medical management for people living with HIV/AIDS.

The U.S. Government is dedicated to improving and modernizing the CARE Act so new advancements in treatments and medical management can continue to help people with HIV/AIDS live longer and healthier lives.

Core indicators for Declaration of Commitment Implementation

Generalized Epidemic Indicators

National Commitment and Action

Percentage of schools that provided life-skills based HIV education in the last academic year.

The HHS/CDC School Health Policies and Programs Study 2006 provides the following related data:

- 84.0 percent of U.S. States and 61.5 percent of School Districts provided funding for, or offered staff development on, HIV-prevention education to health-education teachers;
- 22.9 percent of teachers teaching elementary school classes, covering required health instruction, and of required health-education courses in middle or high schools, had received staff development on HIV-prevention education during the two years preceding the study;
- 48.6 percent of School Districts require the teaching of HIV prevention in elementary schools, 79.0 percent in middle schools, and 89.3 percent in high schools; and
- The median number of hours of HIV-prevention instruction teachers provided was 1.1 hours per school year in elementary school (in elementary school classes in which the topic was taught as part of the required health instruction); and, in required health education courses, 1.5 hours


05/12/2008
Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programs.

Data for this indicator are not available.

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

Data for this indicator are not available.

**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 available to precisely measure this indicator.

- In 2005, there were an estimated 142 infants with perinatal HIV diagnosed in the 35 areas of the United States with mature HIV-surveillance systems, down from an estimated 317 in 2001, a 55-percent reduction.

**Percentage of women and men with advanced HIV infection who are receiving anti-retroviral combination therapy. (HAART).**

No data available to precisely measure this indicator.

**Number of Clients in the United States on HAART, as Reported by Ryan White HIV/AIDS Program-Funded Medical Care Providers by Calendar Year**

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of medical care providers</td>
<td>951</td>
<td>919</td>
<td>895</td>
</tr>
<tr>
<td>Number of medical care providers who reporting valid data</td>
<td>784</td>
<td>911</td>
<td>895</td>
</tr>
<tr>
<td>Number of clients on HAART at the end of the calendar year</td>
<td>171,622</td>
<td>198,420</td>
<td>210,969</td>
</tr>
<tr>
<td>65 percent</td>
<td>70 percent</td>
<td>71 percent</td>
<td></td>
</tr>
</tbody>
</table>

**Data Source: Ryan White CARE Act Data Reports – 2004, 2005, 2006**

HAART = highly active anti-retroviral therapy, one of the US-recommended combination anti-retroviral protocols recommended by the U.S. Government

* Persons with immunological (any CD-4 < 200 cell/µL) or clinical AIDS (any AIDS-defining opportunistic infection) during the calendar year.

† Patients were prescribed HAART during last six months of calendar year, which could overestimate the percentage receiving anti-retroviral combination therapy at year-end.

**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 Fiscal Year (FY) 2004 on permanency planning, and $5.2 million on childcare.

**Percentage of transfused blood units screened for HIV.**

The HHS Food and Drug Administration (FDA) requires the testing of all blood for transfusion in the United States for HIV-1 and HIV-2, with a limited exception for certain autologous (collection and re-infusion of the donor’s own blood) donations. An estimated 100 percent of transfused blood units in the United States 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.**

Data for this indicator are not available.

**Additional Data:**

- 87.9 percent of U.S. students in grades 9-12 have ever been taught about AIDS or HIV infection.
in school (HHS/CDC Youth Behavior Risk Survey, 2005).

Data Source: The Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of priority health-risk behaviors among youth and young adults. It includes a national school-based survey conducted by HHS/CDC and U.S. State and local, school-based surveys conducted by state and local education and health agencies. This report summarizes results from the national survey, 40 state surveys, and 21 local surveys conducted among students in grades 9–12 during October 2004–January 2006.

Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.

According to 2002 National Survey of Family Growth (NSFG) data (the most recent year available):

- Females: 13.0 percent had sex before the age of 15
- Males: 14.6 percent had sex before the age of 15


Additional data:

According to data gathered from the YRBSS, nationwide, 6.2 percent of students had had sexual intercourse for the first time before age 13 years.


Percentage of young women and men aged 15-24 who have had sexual intercourse with more than one partner in the last 12 months.

The National Health and Nutrition Examination Survey (NHANES) gathers information on this indicator for women and men aged 20-59 years:

- Women: 10.0 percent had two or more sexual partners in the last year
- Men: 17.0 percent had two or more sexual partners in the last year

Data Source: NHANES is a cross-sectional survey designed to monitor the health and nutritional status of the civilian, non-institutionalized U.S. population. The survey consists of interviews conducted in participants’ homes, standardized physical examinations conducted in specially outfitted mobile examination centers, and laboratory tests utilizing blood and urine specimens provided by participants during the physical examination.


Additional Data:

NSFG gathers data on the percentage of unmarried women and men aged 15-24 who have had sexual intercourse with more than 1 partner in the last 12 months.

Women: 17.4 percent (from Table 43 in Series 23 Number25)

Men: 25.3 percent (from Table 23 in Series 23 Number26)


Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse.

NSFG gathers data on the percentage of unmarried women and men aged 18-44 who reported condom use during their last intercourse within the last 3 months:

- Women: 31.5 percent (se=1.3)
- Men: 42.2 percent (se=1.6)

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

No data.
**Impact**

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

According to data from HIV case surveillance:

- **Women:** 3.4/100,000
- **Men:** 7.3/100,000
- **Overall rate:** 5.4/100,000


**Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.**

Data for this indicator are not yet available. In the future, this indicator will be measured by HHS/CDC’s Medical Monitoring Project (MMP).

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

- In 2005, there were an estimated 142 infants with perinatal HIV diagnosed in the 33 U.S. states with mature HIV surveillance systems. This was down from an estimated 317 in 2001, a 55 percent reduction.


**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 of most-at-risk populations that have received an HIV test in the last 12 months and who know their results.**

- According to data from the National HIV Behavioral Surveillance System (NHBS), 89 percent of men who have sex with men (MSM) had been tested and received their results.

*Data Source: The NHBS is conducted in 25 metropolitan areas that together account for approximately 60 percent 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. Future cycles will address injecting drug users and high-risk heterosexuals.*

- The NSFG gathers data on the percentage of “higher-risk” women and men aged 15-44 who received an HIV test (outside of blood donation) in the last 12 months, regardless of knowledge about the results:
  - **Women:** 27.9 percent (width of 95 percent CI=3.1)
  - **Men:** 27.4 percent (width of 95 percent CI=4.2)

*Definition of “higher-risk”: Those persons who reported any of the following drug- or sex-related behaviors in the past 12 months (in the audio computer-assisted self-administered interview, or ACASI) were classified as “higher risk for HIV”:

- Injection of illicit drugs
- Use of crack cocaine
- A sex partner who injected illicit drugs
- Exchange of sex for drugs or money
- An HIV-positive partner
- 5 or more sex partners
- Male-male sexual contact
- Treatment for an STD

Percentage of most-at-risk populations reached with HIV prevention programs.
According to data from NHBS, in 2004, 19 percent of MSM were reached with HIV prevention programs.

**Behavior and Knowledge**

**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.**

<table>
<thead>
<tr>
<th>Age</th>
<th>Total*</th>
<th>No.</th>
<th>( percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 — 24</td>
<td>1873</td>
<td>1103</td>
<td>(59)</td>
</tr>
<tr>
<td>&gt;25</td>
<td>5926</td>
<td>2994</td>
<td>(51)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7799</strong></td>
<td><strong>4097</strong></td>
<td><strong>(53)</strong></td>
</tr>
</tbody>
</table>

*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 HHS/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 that together account for approximately 60 percent 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.

**Percent of injecting drug users reporting the use of a condom the last time they had sexual intercourse.**
No data currently available. Risk data on injection drug users (IDU) will be available from NHBS in the future.

**Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected.**
No data currently available. Risk data on injection drug users (IDU) will be available from NHBS in the future.

**Global Commitment and Action**
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, multifaceted initiative active in over 120 countries worldwide. It includes a special focus on 15 severely affected countries.

The initiative’s 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 (OGAC) 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).

In his 2008 State of the Union address, President Bush asked Congress to increase PEPFAR funding from $15 billion to $30 billion.

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

<table>
<thead>
<tr>
<th></th>
<th>FY 2006 PEPFAR</th>
<th>FY07 PEPFAR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Available</td>
<td>Obligations</td>
</tr>
<tr>
<td>Bilateral Activities</td>
<td>2,623,910</td>
<td>2,544,700</td>
</tr>
<tr>
<td>Multilateral Activities</td>
<td>574,200</td>
<td>574,199</td>
</tr>
<tr>
<td><strong>Total FY 2006</strong></td>
<td><strong>3,198,110</strong></td>
<td><strong>3,118,899</strong></td>
</tr>
<tr>
<td><strong>Total FY 2007</strong></td>
<td><strong>4,424,296</strong></td>
<td><strong>3,694,840</strong></td>
</tr>
</tbody>
</table>

**II. Overview of the AIDS Epidemic**

HHS/CDC’s 2005 *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 mature HIV surveillance systems. From 2004 to 2005, the total number of new HIV/AIDS cases in the 33 states increased slightly from 34,833 to 37,163.

Tables 1 and 2 show the estimated number of most-at-risk adults and adolescents diagnosed with HIV/AIDS in 2004 and 2005.

**Table 1. Distribution of the estimated number of diagnoses of HIV/AIDS among adults and adolescents by transmission category in 2004**

<table>
<thead>
<tr>
<th>Transmission Category</th>
<th>Estimated Number of AIDS Cases, in 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Male-to-Male Sexual Contact</td>
<td>16,469</td>
</tr>
<tr>
<td>Injection Drug Use</td>
<td>3,340</td>
</tr>
<tr>
<td>Male-to-Male Sexual Contact and Injection Drug Use</td>
<td>1,311</td>
</tr>
<tr>
<td>Heterosexual Contact</td>
<td>4,107</td>
</tr>
<tr>
<td>Other (hemophilia, blood transfusion, perinatal, and risk not reported or not identified)</td>
<td>125</td>
</tr>
<tr>
<td>Total</td>
<td>25,352</td>
</tr>
</tbody>
</table>

**Table 2. Distribution of the estimated number of diagnoses of HIV/AIDS among adults and adolescents by transmission category in 2005**

<table>
<thead>
<tr>
<th>Transmission Category</th>
<th>Estimated Number of AIDS Cases, in 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Male-to-Male Sexual Contact</td>
<td>18,296</td>
</tr>
<tr>
<td>Injection Drug Use</td>
<td>3,441</td>
</tr>
</tbody>
</table>

Male-to-Male Sexual Contact and Injection Drug Use

<table>
<thead>
<tr>
<th></th>
<th>FY 2005</th>
<th>FY 2006</th>
<th>FY 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual Contact</td>
<td>4,255</td>
<td>7,734</td>
<td>11,989</td>
</tr>
<tr>
<td>Other (hemophilia, blood transfusion, perinatal, and risk not reported or not identified)</td>
<td>139</td>
<td>124</td>
<td>263</td>
</tr>
<tr>
<td>Total</td>
<td>27,455</td>
<td>9,708</td>
<td>37,163</td>
</tr>
</tbody>
</table>

Data Source: HIV/AIDS Surveillance Report 2005, Vol. 17. Rev. ed. Table 1. Estimated numbers of cases of HIV/AIDS, by year of diagnosis and selected characteristics, 2001-2005 – 33 states and U.S. dependent areas with confidential name-based HIV infection reporting (Revised June 2007). Note: these numbers do not represent reported case counts. Rather, these numbers are point estimates, which result from adjustments of reported case counts. These data are from the 33 states only.

### III. National Response to the AIDS Epidemic

#### Prevention

- HHS/CDC’s *HIV Prevention Strategic Plan: Extended Through 2010* ensures HHS/CDC is responsive to the changing epidemic, scientific advances, and new scientific opportunities.
- HHS/CDC’s HIV prevention programs are guided by and supportive of a national health-promotion and disease-prevention agenda, known as *Healthy People 2010*, which includes specific objectives to reduce HIV/AIDS.
- In 2006, the CDC issued revised HIV testing guidelines, calling for routine, opt-out HIV testing for all Americans, ages 13-64, in healthcare settings.
- In 2007, HHS/CDC launched the Heightened National Response to the HIV/AIDS Crisis Among African Americans to meet the public health needs of African Americans and reduce the burden of HIV/AIDS in African American communities. The initiative has four key areas of focus: 1) expanding the reach of prevention services, 2) increasing opportunities for diagnosing and treating HIV, 3) developing new, effective prevention interventions, and 4) mobilizing broader community action.
- In that same year, CDC also began to implement the President’s Domestic HIV Testing Initiative, aimed at increasing the number of Americans who are aware of their infection. Increased funding was made available to support programs targeted toward areas and populations that are disproportionately impacted by HIV/AIDS.

#### Care/Treatment and Support

- The CARE Act provided $2.4 billion in FY 2007 for HIV/AIDS health care and health-related supportive and ancillary services.
- *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 2005-2007 in U.S. dollars.

#### Table 3. Treatment expenditures (non-RWCA)

<table>
<thead>
<tr>
<th></th>
<th>FY 2005</th>
<th>FY 2006</th>
<th>FY 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare/Medicaid</td>
<td>$5,700 billion</td>
<td>$3,900 billion</td>
<td>$41,000 billion</td>
</tr>
<tr>
<td>Substance Abuse and Mental Health Services Administration (SAMHSA)</td>
<td>$73.9 million</td>
<td>$71.6 million</td>
<td>$73.5 million</td>
</tr>
<tr>
<td>Minority AIDS Initiative</td>
<td>$136.7 million</td>
<td>$137.2 million</td>
<td>$139.8 million</td>
</tr>
<tr>
<td>Global AIDS Trust Fund</td>
<td>$99.2 million</td>
<td>$99.0 million</td>
<td>$99.0 million</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$6,009,800</td>
<td>39,307,800</td>
<td>4,412,300</td>
</tr>
</tbody>
</table>

#### 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 they can adhere to 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 2006, these services were provided by the following number of Ryan White HIV/AIDS Program-funded providers:

- Case Management: 1,379
- Housing Assistance: 551
- Nutritional Assistance:
  - Food bank/home delivered meals: 596
  - Nutritional counseling: 567
- Emergency Financial Assistance: 561
- Client Advocacy: 616
- Psychosocial Support: 717
- Substance Abuse Treatment: 489
- Mental Health Treatment: 885

Transportation services (provided by 869 Ryan White HIV/AIDS Program providers in 2006) also help people get to their primary care appointments.

HHS/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 one quarter 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 two and four 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. 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 (HHS/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 (Institute of Medicine (IOM) 2004). CARE Act 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. President Bush has reaffirmed a commitment to addressing HIV/AIDS in the U.S., with support for initiatives such as the Domestic HIV Testing Initiative – which focuses support for increased testing in areas and populations disproportionately impacted by HIV. In addition, CDC has launched the Heightened National Response (mentioned above) to address the ongoing crisis of HIV/AIDS among African Americans in the U.S. The Ryan White CARE Act was reauthorized in 2007 and targets CARE Act 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). HHS 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 U.S. Government 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, 48 states have implemented name-based HIV surveillance and the remaining 2 states are actively developing implementation plans. HHS/CDC provides technical assistance to states to improve their surveillance systems. In addition, HHS/CDC has implemented national HIV incidence surveillance. The first national HIV incidence estimated from this new surveillance system are expected to be released in 2008.

7. The shift from acute-care needs to chronic-care needs has not been reflected in the HIV care delivery system (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

HHS/CDC is responsible for accurately monitoring the HIV/AIDS epidemic in the United States. Each year, the HHS/CDC publishes an HIV/AIDS Surveillance Report which provides data on the state of the epidemic in the U.S. broken out by geographic area, race/ethnicity and risk. In addition, CDC supports surveillance for HIV related risk behaviors among youth, risk populations and the general public and has initiated a new survey to monitor provision of care for HIV-infected persons. The HIV/AIDS Bureau at HRSA will begin in tracking client-level data on utilization of services in 2009.

Additional information:

The U.S. National Institutes of Health (NIH) has established the largest and most significant AIDS research program in the world: a comprehensive and global trans-NIH research effort totaling more than $2.9 billion in FY 2006 and in FY 2007. NIH supports and conducts a comprehensive program of basic, clinical, and behavioral research on HIV infection and its associated coinfections, opportunistic infections, malignancies, and other complications. NIH conducts and supports research in its own laboratories as well as in research institutions in the U.S. and around the world. NIH-funded research has lead to the discovery of antiretroviral therapies and regimens that have resulted in improved quality of life and life expectancy for those with access to these drugs. In addition, NIH research has led to the development of treatments for some HIV-associated co-infections and co-morbidities, including malignancies, neurological complications, tuberculosis, and other clinical manifestations. NIH research also has led to a number of advances in HIV prevention, including strategies for the prevention of mother-to-child transmission and the demonstration that medically supervised circumcision of adult men can reduce risk of heterosexual HIV acquisition.

- NIH HIV Microbicide Research: In FY 2006, NIH invested $85.7 million in basic, clinical and behavioral research related to the development of microbicides; in FY 2007 NIH spent $96.4 million in research in this area.
- NIH HIV Vaccine Research: In FY 2006, NIH invested $581.5 million in basic, clinical, and behavioral research related to the development of HIV vaccines. In FY 2007, NIH spent $582.4 million for research in this area.

**Bibliography**


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