

*UNAIDS Global AIDS Response Progress Reporting 2012*  
**UNITED STATES OF AMERICA** Country Progress Report

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**I. Status at a glance**

**(a) the inclusiveness of the stakeholders in the report writing process;**

The report writing and review process consisted of U.S. government interagency effort including Department of Health and Human Services (HHS), Department of Education, Department of Justice, Department of Labor, and Department of State. Each department was queried on the indicators relative to their agency and was responsible for collecting and analyzing data and reporting on their respective indicators. The HHS Office of HIV/AIDS and Infectious Disease Policy assembled this report and submitted through interagency clearance. Furthermore, there were public comment opportunities on HIV/AIDS related issues via [www.AIDS.gov](http://www.AIDS.gov) – a website responsible for coordinating HIV/AIDS related information across the federal government.

In the fall of 2011, the White House Office of National AIDS Policy (ONAP) convened community forums across the country to focus attention on issues related to implementation of the National HIV/AIDS Strategy. These events were a forum for federal, state and local agency representatives, researchers, clinicians, the HIV community, and leaders from the business, foundation, faith, and media sectors to share their diverse expertise and collaborative experience. These forums provided opportunities for individual citizens to present White House staff and other policy makers with their recommendations for achieving the President's three goals for the NHAS, of reducing new HIV infections, improving access to care and health outcomes, reducing HIV-related health disparities, and improving the coordinated national response to HIV/AIDS. A final report titled "Community Ideas for Improving the Response to the Domestic HIV Epidemic" was published in April 2010.

**(b) the status of the epidemic;**

During 2010-2011, the United States government 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. At the end of 2010, an estimated 1.2 million persons aged 13 and older were living with HIV infection in the United States. Of those, 20 percent had undiagnosed HIV infections. Despite increases in the total number of people in the U.S. living with HIV infection in recent years (due to better testing and treatment options), the annual number of new HIV infections has remained relatively stable. However, new infections continue at far too high of a level, with approximately 50,000 Americans becoming infected with HIV each year. The estimated rate of diagnosis of HIV infection (in the 46 states with confidential name-based HIV infection reporting since at least January 2007) was 16.1 per 100,000. The rate among adult and adolescent males was 31.4 per 100,000 and the rate among females was 8.0 per 100,000. The estimated rate of AIDS diagnoses was 10.8 per 100,000. An estimated 17,774 people with AIDS died in 2009, and nearly 619,400 people with AIDS in the U.S. have died since the epidemic began.<sup>1</sup>

In 2010, of diagnosed HIV infections an estimated 77 percent among males were attributed to male-to-male sexual contact, and 86 percent among females were attributed to heterosexual contact. In 2010, males accounted for 79 percent of all diagnoses of HIV infection among adults and adolescents. In 2010, diagnosed infections attributed to male-to-male sexual contact (61 percent) (men who have sex with men (MSM) account for just 2 percent of the US population) and the infections attributed to heterosexual contact (27 percent) accounted for approximately 88 percent of diagnosed HIV infections in the 46 states. In 2010, blacks/African Americans accounted for 46 percent of all diagnoses of HIV infection, yet represented only approximately 14 percent of the US population. In 2010, the largest percentage of all diagnoses (16 percent) and the highest rate per 100,000 population (36.9) were those for persons aged 20–24 years. The data provided in the report represent the most recent data the Centers for Disease Control and Prevention had available at the time the report was developed.<sup>2</sup>

**(c) the policy and programmatic response;**

During 2010-2011, the United States government continued its commitment to turning the tide of the domestic and global HIV and AIDS pandemic. On July 13, 2010, the White House released the National HIV/AIDS Strategy (NHAS). This ambitious plan is the nation's first-ever comprehensive coordinated HIV/AIDS roadmap with clear and measurable targets to be achieved by 2015 in reducing new HIV infections, improving access to care and health outcomes, and reducing HIV-related disparities. The vision of the NHAS is *"The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination."*

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act and set into place an effort that will help ensure Americans have secure, stable, affordable health insurance and the relief they need from skyrocketing health insurance costs. Historically, people living with HIV and AIDS have had a difficult time obtaining private health insurance and have been particularly vulnerable to insurance industry abuses. People with HIV and AIDS also face barriers to obtaining care from qualified providers. Consistent with the goals of the President's NHAS, the

Affordable Care Act makes considerable strides in addressing these concerns and advancing equality for people living with HIV and AIDS.<sup>3</sup>

Departments and agencies across the United States government had many advances in 2010-2011 supporting HIV/AIDS research, prevention, treatment, and care. Below are highlights of policy and programmatic responses within this reporting period.

### **Department of Health and Human Services (HHS)**

In 2010-2011, the Presidential Advisory Council on HIV/AIDS (PACHA) continued to provide policy recommendations on the U.S. government's response to the HIV/AIDS epidemic. PACHA provides advice, information, and recommendations to the Secretary of Health regarding programs and policies intended to promote effective prevention of HIV disease, and to advance research on HIV disease and AIDS. The Secretary of Health and Human Services provides the President with all products provided to the Secretary by the PACHA.

In January 2010, after 22 years, the US HIV travel ban was lifted, thus removing HIV from the list of communicable diseases which make visitors ineligible for entry into the U.S. An immediate result of the change in law was the decision of the International AIDS Society to select the city of Washington, D.C., to host the 2012 International AIDS Conference.

In 2010, HHS launched the 12 Cities Project to address the fourth goal of the NHAS to improve the coordination, collaboration, and integration of federally-funded HIV programs in the 12 jurisdictions that bear the highest AIDS burden in the country. Specific actions of the 12 Cities Project include: data sharing across organizational lines; cross-agency training; and implementation of common performance metrics. An evaluation of the 12 cities will identify key themes across jurisdictions, unique challenges and successes, and lessons learned that may be applied to the ongoing 12 Cities Project and to other jurisdictions.

### **HHS Health Resources and Services Administration (HRSA)**

In 2010-2011, HRSA continued to implement the Ryan White HIV/AIDS Treatment Extension Act of 2009 (S.1793, P.L. 111-87) (CARE Act), to improve the quality and availability of care for low-income, uninsured, and underinsured individuals and families affected by HIV disease for over 500,000 people living with HIV/AIDS in the United States. In December 2011, the President of the United States announced a \$50 million funding increase for domestic HIV/AIDS treatment and care through two mechanisms: 1) \$15 million for the HRSA Ryan White program for HIV medical clinics across the country; and 2) \$35 million for state AIDS Drug Assistance Programs (ADAP).<sup>4</sup>

### **HHS Centers for Disease Control and Prevention (CDC)**

In 2010, CDC launched the Enhanced Comprehensive HIV Prevention Plan (ECHPP) initiative, with a focus on grantees conducting a situational analysis and consider the following: local resources; epidemiologic profiles; available efficacy, cost, and cost-effectiveness data for specific interventions and strategies; and priority areas from existing local plans. The grantees used these data to develop a set of goals, strategies, and specific objectives to achieve an optimal combination of prevention

activities to reach NHAS goals. In August 2011, CDC implemented a new funding algorithm for its cooperative agreement with state and local health departments (PS 12-1201) to better align funding according to disease burden. CDC's new funding opportunity for health departments includes a category for funding innovative approaches to prevention, including those focused on HIV testing approaches that increase identification of undiagnosed infections or improve cost effectiveness and enhanced linkage to and retention in medical care for individuals living with HIV.

### **HHS National Institutes of Health (NIH)**

In October 2011, NIH updated its HIV Treatment Guidelines for treating HIV-infected adults and adolescents, including utilization of resistance testing, initiation of treatment, preferred first-line regimens, adverse events to antiretroviral medications, managing treatment-experienced patients, and considerations for special populations. This revision to the guidelines was focused on "What to Start: Initial Combination Regimens for the Antiretroviral-Naive Patient."<sup>5</sup> NIH continues to support a substantial research portfolio to develop evidence-based prevention and treatment interventions to combat HIV/AIDS.

### **HHS Substance Abuse and Mental Health Services Administration (SAMHSA)**

In July 2011, SAMHSA introduced a new application process for its community mental health services block grant (MHBG) and substance abuse prevention and treatment block grant (SABG), giving states greater flexibility in allocating MHBG resources for mental health promotion, treatment and recovery services and SABG resources for substance use disorder prevention, treatment, and recovery services in their communities. SAMHSA also revised the SABG application and included new reporting requirements specifically for states using HIV designated funding. The new measures include the number of HIV programs funded in the state, the number of individuals tested, number of tests conducted, the number of positive tests, etc.<sup>6</sup> In December 2011, SAMHSA released an advisory on rapid HIV testing and the benefits of its use in substance abuse treatment facilities. The advisory summarized testing regulations and outlines the procedures for implementing the testing, including factors associated with pretest and posttest counseling.

### **HHS Centers for Medicare and Medicaid Services (CMS)**

In June 2011, CMS published a State Medicaid Director letter to remind states and stakeholders about the various Medicaid options that exist to increase access and improve care coordination for people with HIV/AIDS and to assist them in their efforts to take advantage of these options. The letter also advises states in efforts to cover pre-disabled people living with HIV through 1115 waivers. Specifically, the letter offers technical assistance and a waiver template designed to simplify and expedite the waiver application process.

### **State Department Office of the U.S. Global AIDS Coordinator (OGAC)**

The State Department's Office of the U.S. Global AIDS Coordinator oversees the implementation of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the U.S. government initiative to support partner nations around the world in responding to HIV/AIDS. PEPFAR was launched in 2003, and is the largest commitment by any nation to combat a single disease internationally in history. As of September 30, 2011, the U.S. directly supported life-saving antiretroviral treatment

for more than 3.9 million men, women, and children worldwide. PEPFAR directly supported HIV testing and counseling for more than 9.8 million pregnant women in fiscal year 2011. PEPFAR supported antiretroviral drug prophylaxis to prevent mother-to-child transmission for more than 660,000 of these women who tested positive for HIV, allowing approximately 200,000 infants to be born HIV-free. PEPFAR directly supported nearly 13 million people with care and support, including more than 4.1 million orphans and vulnerable children, in fiscal year 2011. PEPFAR directly supported HIV counseling and testing for more than 40 million people in fiscal year 2011, providing a critical entry point to prevention, treatment, and care.<sup>7</sup>

In addition to the considerable HHS investment in HIV vaccine research carried out by the NIH, the United States Agency for International Development (USAID), through a Congressional Directive, supports HIV and AIDS vaccine research and development through its public-private partnership with the International AIDS Vaccine Initiative (IAVI). The IAVI program has enabled the testing of promising candidate HIV vaccines through improving vaccine design while increasing in-country research capacity and infrastructure. The U.S. government investment has also resulted in noteworthy scientific breakthroughs such as the landmark 2011 discovery of treatment as prevention.

## **II. Overview of the AIDS epidemic**

During 2010-2011, the United States government continued its commitment to turning the tide of the domestic and global HIV and AIDS pandemic. The United States is categorized as having a concentrated/low-prevalence epidemic. At the end of 2010, an estimated 1.2 million persons aged 13 and older were living with HIV infection in the United States. Of those, 20 percent had undiagnosed HIV infections. Despite increases in the total number of people in the United States living with HIV infection in recent years (due to better testing and treatment options), the annual number of new HIV infections has remained relatively stable. However, new infections continue at far too high of a level, with approximately 50,000 Americans becoming infected with HIV each year. The estimated rate of diagnosis of HIV infection (in the 46 states with confidential name-based HIV infection reporting since at least January 2007) was 16.1 per 100,000. The rate among adult and adolescent males was 31.4 per 100,000 and the rate among females was 8.0 per 100,000. The estimated rate of AIDS diagnoses was 10.8 per 100,000. An estimated 17,774 people with AIDS died in 2009, and nearly 619,400 people with AIDS in the U.S. have died since the epidemic began.<sup>8</sup>

In 2010, of diagnosed HIV infections an estimated 77 percent among males were attributed to male-to-male sexual contact, and 86 percent among females were attributed to heterosexual contact. In 2010, males accounted for 79 percent of all diagnoses of HIV infection among adults and adolescents. In 2010, diagnosed infections attributed to male-to-male sexual contact (61 percent) (men who have sex with men (MSM) account for just 2 percent of the U.S. population) and the infections attributed to heterosexual contact (27 percent) accounted for approximately 88 percent of diagnosed HIV infections in the 46 states. In 2010, blacks/African Americans accounted for 46 percent of all diagnoses of HIV infection, yet represented only approximately 14 percent of the U.S. population. In 2010, the largest percentage of all diagnoses (16 percent) and the highest rate per

100,000 population (36.9) were those for persons aged 20–24 years. The data provided in the report represent the most recent data CDC had available at the time the report was developed.<sup>9</sup>

### **III. National Response to the AIDS epidemic**

During 2010-2011, the United States government has continued its commitment to turning the tide of the domestic and global HIV/AIDS pandemic. On July 13, 2010, the White House released the National HIV/AIDS Strategy (NHAS). This ambitious plan is the nation's first-ever comprehensive coordinated HIV/AIDS roadmap with clear and measurable targets to be achieved by 2015 in reducing new HIV infections, improving access to care and health outcomes, and reducing HIV-related disparities. The vision of the NHAS is *"The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination."*

The U.S. Department of Health and Human Services (HHS), along with five other "lead federal agencies" (Departments of Justice, Labor, Housing and Urban Development, Veterans Affairs, and Social Security Administration), were called upon to develop and submit operational plans to the White House Office of National AIDS Policy (ONAP) and the Office of Management and Budget (OMB) within 150 days of the NHAS release date and the issuance of a Presidential Memorandum for the heads of executive departments and agencies. The memorandum directed that the operational plans include "appropriate actions to advance the Strategy," as well as "steps to strengthen coordination in planning, budgeting for, and evaluating domestic HIV/AIDS programs within and across agencies." In February 2011, the designated lead agencies released their operational plans and continue to convene interdepartmental and intradepartmental meetings.

During 2010-2011, the Department of Health and Human Services convened consultations with civil society regarding: funding policies and formulas; development of State plans; planning for the implementation strategy fund; engagement of Lesbian, Gay, Bisexual and Transgender (LGBT) national organizations; and public leadership of people living with HIV/AIDS.

### **IV. Best Practices**

The nation's HIV prevention efforts are guided by a single, ambitious strategy for combating the epidemic: the National HIV/AIDS Strategy (NHAS). Recent scientific breakthroughs have equipped us with an unprecedented number of effective tools to prevent infection. And in many of the communities hardest hit by HIV, there is growing leadership and momentum for change.

Yet the challenges remain daunting. As a result, the number of people living with HIV in the United States, now at nearly 1.2 million, continues to grow by tens of thousands each year, creating more opportunities for HIV transmission. And a range of social, economic, and demographic factors affect some Americans' risk for HIV, such as stigma, discrimination, substance use, income, education, and geographic region. While current prevention efforts have helped to keep the number of new

infections stable in recent years, continued growth in the population living with HIV will ultimately lead to more new infections if prevention, care, and treatment efforts are not intensified.

To address these challenges, CDC and its partners are pursuing a High-Impact Prevention<sup>10</sup> approach to reducing new HIV infections. By using combinations of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas, this approach promises to increase the impact of HIV prevention efforts – an essential step in achieving the goals of NHAS. This approach is designed to maximize the impact of prevention efforts for all Americans at risk for HIV infection, including gay and bisexual men, communities of color, women, youth, injection drug users, and transgender women and men.

Research has led to a growing number of proven, cost-effective approaches to reduce the risk of HIV infection. Many of these approaches can be particularly effective when tailored to address the social, community, financial, and structural factors that place specific groups at risk. In the United States, proven strategies include: HIV testing and linkage to care; antiretroviral therapy; access to condoms and sterile syringes (in United States no federal funds are used for access to sterile syringes); prevention programs for people living with HIV and their partners; prevention programs for people at high risk of HIV infection; substance abuse treatment; screening and treatment for other sexually transmitted infections; and pre-exposure prophylaxis (PrEP).

In addition, research has shown that early treatment of HIV infected individuals prevents transmission of the virus to uninfected, intimate partners as was shown in HPTN 052, a trial that was named breakthrough of the year in 2011. NIH is supporting research to optimize implementation of HIV treatment as prevention, particularly for vulnerable populations such as those within the criminal justice system and those who engage in drug abuse and other high risk behaviors.

## **V. Major Challenges and Remedial Actions**

### **(a) progress made on key challenges reported 2010 Country Progress Report, if any;**

During 2010-2011 the United States created and released the first-ever National HIV/AIDS Strategy with an accompanying Federal Implementation Plan. We have made significant progress on improving surveillance systems, increasing access to HIV/AIDS care and treatment, and supporting most-at-risk populations.

### **(b) challenges faced throughout the reporting period (2010-2011) that hindered the national response, in general, and the progress towards achieving targets, in particular;**

None

### **(c) concrete remedial actions that are planned to ensure achievement of agreed targets.**

The United States will continue to implement the National HIV/AIDS Strategy and the goals set for 2015.

## **VI. Support from the country's development partners (if applicable)**

Not Applicable.

## **VII. Monitoring and evaluation environment**

### **(a) an overview of the current monitoring and evaluation (M&E) system**

CDC is primarily responsible for monitoring the HIV/AIDS epidemic in the United States. Each year, the CDC publishes an *HIV 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 HRSA HIV/AIDS Bureau began tracking client-level data on utilization of services in 2011, but data was not available at the time this report was prepared.

### **(b) challenges faced in the implementation of a comprehensive M&E system**

Challenges and limitations exist in implementing a comprehensive M&E system in the United States. Some data monitoring limitations include the lack of a standardized surveillance and reporting system. Other challenges exist in potential underreporting, duplicate reporting, or reporting variances across agencies leading to inaccurate counts. Supporting existing surveillance methods to identify populations at greatest risk that need to be targeted for HIV prevention services is central to the National HIV/AIDS Strategy for the United States. As of December 2011, all states have switched to names-based HIV infection reporting systems, which is expected to improve the quality of national surveillance reporting. Confidential, name-based HIV case surveillance is conducted in all states, the District of Columbia, and U.S. territories, and the separately-funded cities of Chicago, Houston, Los Angeles, New York, Philadelphia, and San Francisco.

### **(c) remedial actions planned to overcome the challenges**

The National HIV/AIDS Strategy will be addressing M&E challenges.

### **(d) highlight, where relevant, the need for M&E technical assistance and capacity-building. Countries should base this section on the National Commitments and Policy Instrument (NCPI) (see Appendix 3).**

Technical assistance and capacity-building is necessary at all levels of reporting due to the significant overlap of resources being utilized and services being provided at the local, state, and national level.

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<sup>1</sup> <http://www.cdc.gov/hiv/topics/surveillance/resources/reports>

<sup>2</sup> <http://www.cdc.gov/hiv/topics/surveillance/basic.htm>

<sup>3</sup> <http://www.aids.gov/federal-resources/policies/health-care-reform>

<sup>4</sup> <http://www.whitehouse.gov/the-press-office/2011/12/01/fact-sheet-beginning-end-aids>

<sup>5</sup> <http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf>

<sup>6</sup> <http://www.samhsa.gov/newsroom/advisories/1104110222.aspx>

<sup>7</sup> <http://www.pepfar.gov/results/index.htm>

<sup>8</sup> <http://www.cdc.gov/hiv/topics/surveillance/resources/reports>

<sup>9</sup> <http://www.cdc.gov/hiv/topics/surveillance/basic.htm>

<sup>10</sup> [http://www.cdc.gov/hiv/strategy/dhap/pdf/nhas\\_booklet.pdf](http://www.cdc.gov/hiv/strategy/dhap/pdf/nhas_booklet.pdf)