

NATIONAL HIV/AIDS STRATEGY FOR THE UNITED STATES



2010

Vision for the National HIV/AIDS Strategy



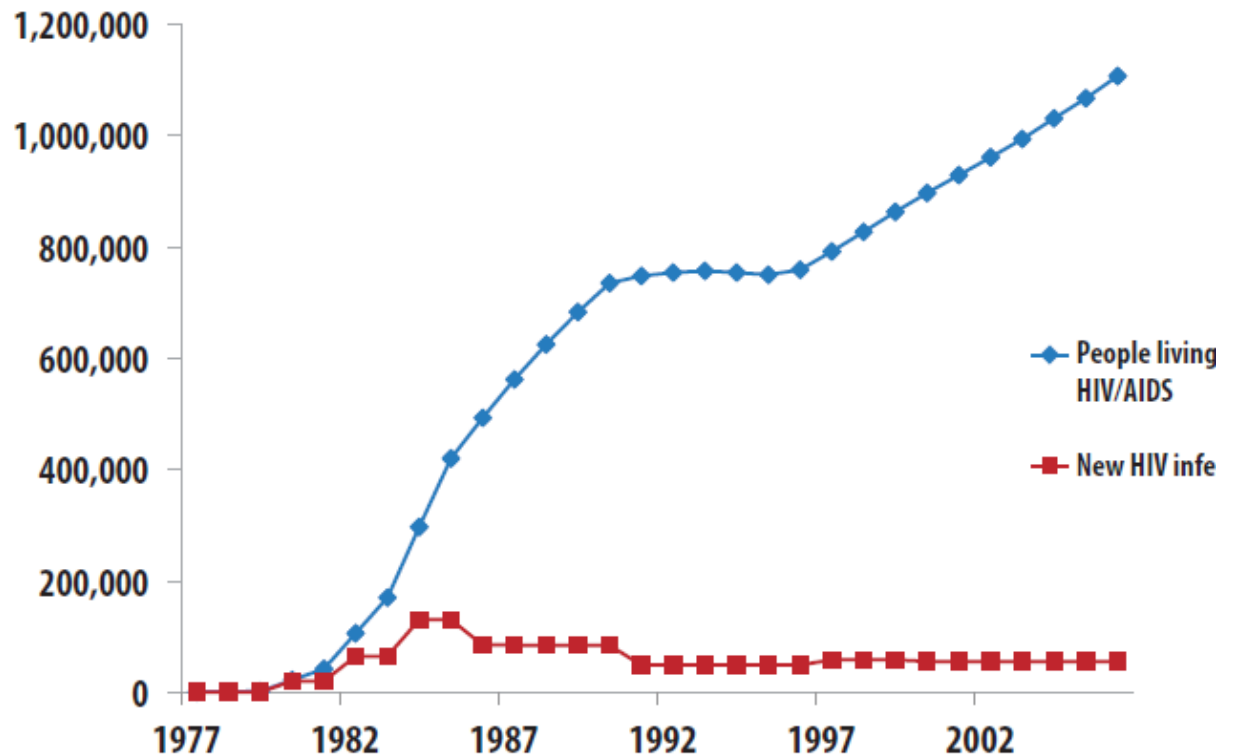
“The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination”



Key facts: HIV in the United States

- The epidemic has claimed the lives of nearly 600,000 Americans and affects many more
- Approximately 56,000 people become infected each year and more Americans are living with HIV than ever before
- More than 1.1 million Americans are living with HIV

Figure 1. Estimates of Annual HIV Infections and People Living with HIV/AIDS (1977-2006)

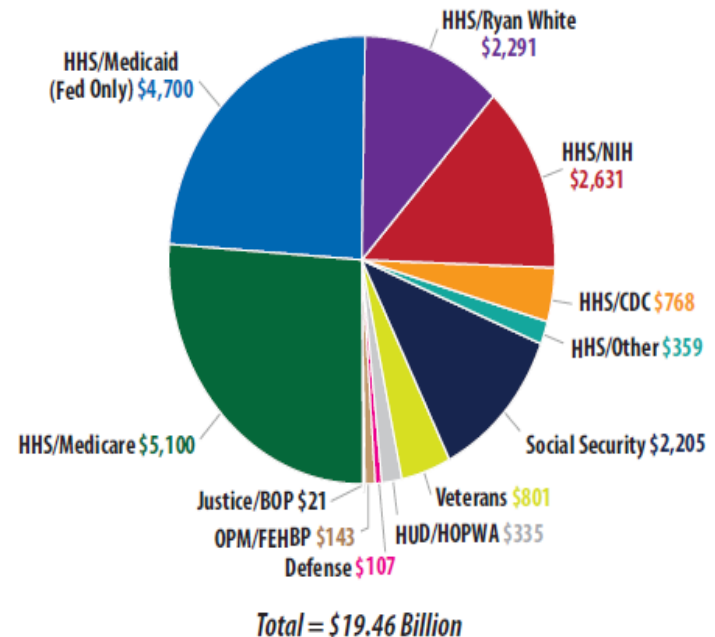


Sources: Hall et al, JAMA, 2008; and MMWR, October 3, 2008.

Key Facts: HIV/AIDS Domestic Funding

- Roughly half of Federal funding for domestic HIV services flows through Medicaid and Medicare – but the structure of the programs makes it difficult to adapt to HIV policy goals
- More flexible programs still face competing rules, data collection requirements, and purposes that create administrative burdens
- Resources to prevent HIV infection are not distributed proportionately to the disease burden
- Few federal HIV funding programs are designed to encourage efficient coordination across programs

Figure 5. Federal Funding for Domestic HIV/AIDS, FY 2010
(in millions \$)



Source: FY 2010 Appropriations. HHS other includes (in millions \$) SAMHSA (\$178), FDA (\$109), Office of the Secretary (\$64), Indian Health Service (\$5), and AHRQ (\$3).

Challenges



- Approximately 1 in 5 people living with HIV are unaware of their status
- Roughly 3/4 of HIV/AIDS cases in the United States are among men, the majority of whom are gay and bisexual men.
- 1/4 of Americans living with HIV are women, and the disease disproportionately impacts women of color.
- Racial and ethnic minorities are disproportionately represented in the HIV epidemic and die sooner than Whites.
- The South and Northeast, along with Puerto Rico and the U.S. Virgin Islands, are disproportionately impacted by HIV.
- 1/4 of new HIV infections occur among adolescents and young adults (ages 13 - 29).
- 24% of people living with HIV are 50 or older, and 15% of new HIV/AIDS cases occur among people in this age group.



1.) Gay and bisexual men

Gay men comprise approximately 2% of the U.S. population, but 53% of new infections

2.) Black men and women

Black men and women represent only 13% of the population, but account for 46% of people living with HIV

3.) Latinos and Latinas

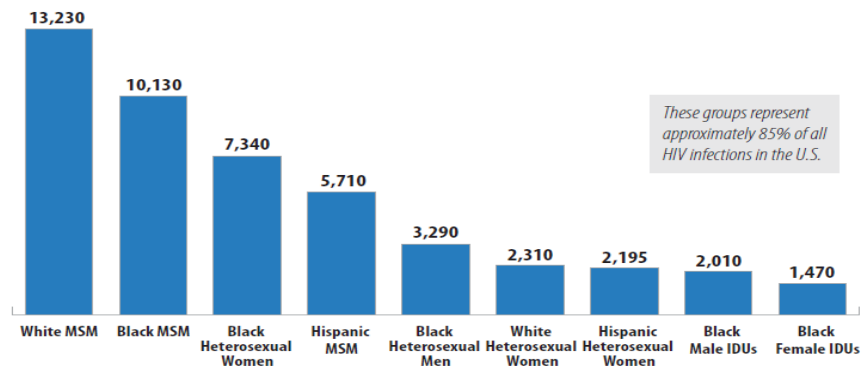
The rate of new AIDS diagnoses among Latino men is 3-times that of White men, and the rate among Latinas is 5-times that of White women

4.) Substance abusers:

There is an estimated 1 million injection drug users (IDUs), but injection drug use accounts for approximately 16 % of new HIV infections in the U.S.

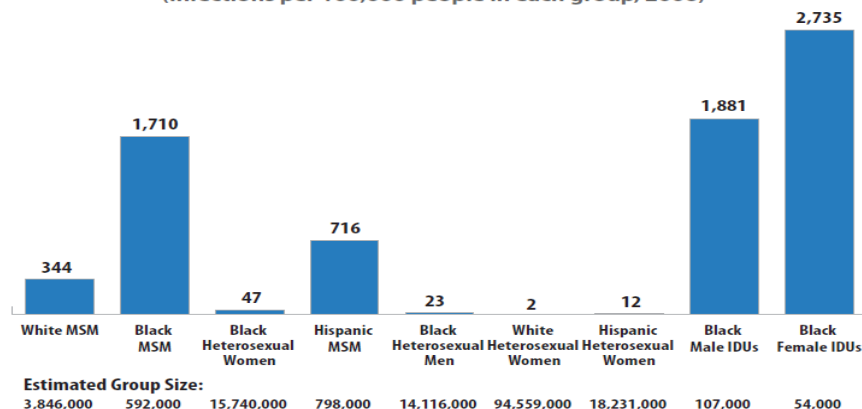
Focus Area: High Risk Groups

Figure 2. Numbers of Annual HIV Infections by High-Risk Groups (2006)



Sources: *MMWR*, October 3, 2008 and *MMWR*, June 5, 2009 with the addition of incidence data for Puerto Rico based on an analysis by Holtgrave, D., Johns Hopkins Bloomberg School of Public Health. For this analysis, all Puerto Rico cases were classified as Hispanic. Chart based upon CDC, *HIV Prevention in the United States at a Critical Crossroads*, 2009. MSM = men who have sex with men (gay and bisexual men) and IDUs = injection drug users.

Figure 3. Estimated Risk for HIV Infection for High-Risk Groups (Infections per 100,000 people in each group, 2006)



Source: Holtgrave, D., Johns Hopkins Bloomberg School of Public Health based on analysis of HIV incidence in the 50 states from *MMWR*, October 3, 2008, with the inclusion of HIV incidence for Puerto Rico, where all Puerto Rico cases were classified as Hispanic and taken from CDC's *MMWR*, June 5, 2009. Population sizes for 2006 are rounded estimates derived from analysis of the following sources: Statistical Abstract US, 2009; CDC estimate of 4% of men are MSM (MSM denotes men who have sex with men); The National Survey on Drug Use and Health Report, October 29, 2009; Brady et al., *Journal of Urban Health* 2008; and Thierry et al., *Emerging Infectious Diseases*, 2004.

National HIV/AIDS Strategy: Primary Goals



Goal 1: Reducing the number of people who become infected with HIV

Goal 2: Increasing access to care and optimizing health outcomes for people living with HIV

Goal 3: Reducing HIV-related health disparities

Key Steps to Achieve the Goals



Goal 1: Reducing Infections

- Intensify HIV prevention efforts in communities where HIV is most heavily concentrated.
- Expand targeted efforts by effective, evidence-based approaches.
- Educate Americans about the threat of HIV and how to prevent it.

Goal 2: Increasing Access to Care

- Establish a system to link people to continuous and coordinated quality care when diagnosed with HIV.
- Increase the number and diversity of service providers for people living with HIV.
- Support people living with HIV (e.g. housing).

Goal 3: Reducing disparities

- Reduce HIV-related mortality in high risk communities.
- Adopt community-level approaches to reduce HIV infection.
- Reduce stigma and discrimination against people living with HIV.

Anticipated Results by 2015



- Lower the annual number of new infections by 25 %
- Increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65 % to 85 %
- Increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care from 73 % to 80 %
- Increase the percentage of Ryan White HIV/AIDS Program clients with permanent housing from 82 % to 86 %
- Increase the proportion of HIV diagnosed gay and bisexual men, Blacks and Latinos with undetectable viral load by 20 %

A Plan for Achieving the National Strategy



- **In order for the National HIV/AIDS Strategy to be successful, emphasis must be placed on coordination of activities among agencies and across all levels of government by:**
 - 1.)** Increasing the coordination of HIV programs across the Federal Government and between Federal agencies and State, territorial, local, and tribal governments.
 - *Ensure coordinated program administration*
 - *Promote equitable resource allocation*
 - *Streamline and standardize data collection*
 - 2.)** Developing improved mechanisms to monitor and report on progress toward achieving national goals.
 - *Provide rigorous evaluation of current programs*
 - *Provide regular public reporting*
 - *Encourage States to provide regular progress reports*

Recommendations



- Resource allocation decisions for programs should be grounded in the latest epidemiological data.
- People living with HIV have unique experience that should be valued and relied upon as a critical source of input in setting policy.
- Communities themselves are often the best equipped to make difficult trade-offs, and priority setting and resource allocation is best done as close to ground as possible.
- Continued investment in research is needed – biomedical, biomedical prevention, health services, operations and behavioral research.
- A commitment to innovation is needed to keep pace with an evolving epidemic, a scarcity of resources, and to support communities.

Conclusion



“With government at all levels doing its part, a committed private sector, and leadership from people living with HIV and affected communities, the United States can dramatically reduce HIV transmission and better support people living with HIV and their families.”