UNGASS COUNTRY PROGRESS REPORT

United States of America

Reporting Period: January 2008 – December 2009
Submission Date: March 31, 2010

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II. 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 intra-agency effort including Department of Health and Human Services (HHS), Department of Education, Department of Justice and 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 Policy and Office of Global Health Affairs assembled this report and submitted through intra-agency clearance.

Civil society was offered a public comment period during the development of the U.S. National HIV/AIDS Strategy (NHAS) in the fall of 2009 and asked to provide input via the White House Office of National AIDS Policy (ONAP) website. ONAP and HHS Office of HIV/AIDS Policy held a series of forums from late summer through the end of 2009 in various regions of the country with diverse communities impacted by HIV/AIDS. 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. The White House report summarizing recommendations was released April 9, 2010 (The link to the report is: http://www.whitehouse.gov/sites/default/files/microsites/ONAP_rpt.pdf)Furthermore, there are public comment opportunities on HIV/AIDS related issues via www.AIDS.gov – a website responsible for coordinating HIV/AIDS related information across the Federal government.

(b) The status of the epidemic;
During 2008-2009, 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. The Department of Health and Human Services'(HHS), Centers for Disease Control and Prevention(CDC) estimates indicate that 1,106,400 people were living with HIV in the United States in 2006, of whom 21 percent were undiagnosed. The number of new HIV infections diagnosed in 2006 was approximately 56,300. Although these results are within the range of previous estimates, the back-calculation suggests that the previous CDC estimate of approximately 40,000 cases each year underestimated the severity of the epidemic. The new national estimate of 56,300 does not reflect an increase in new HIV infections from previous years, but a more accurate direct measurement of incidence.

*The data provided in the report represent the most recent data CDC had available at the time the report was developed.

(c) The policy and programmatic response; and

During 2008-2009, the United States Government has continued its commitment to turning the tide of the domestic and global HIV/AIDS pandemic. Departments and agencies across the United States Government have had many advances in the past year supporting HIV/AIDS research, prevention, treatment and care. Below are highlights of policy and programmatic responses within this reporting period.

HHS

In 2009, the charter for the Presidential Advisory Council on HIV/AIDS (PACHA) was renewed and amended, and a highly diverse group of 25 citizens were appointed as new members. PACHA was established to provide policy recommendations on the U.S. Government's response to the AIDS epidemic. PACHA provides advice, information, and recommendations to the Secretary regarding programs and policies intended to promote effective prevention of HIV disease, and to advance research on HIV disease and AIDS. The role of PACHA is solely advisory. The Secretary provides the President with copies of all written reports provided to the Secretary by the Advisory Council.

After 22 years, on October 2009, the U.S. HIV travel ban was lifted. The new law took effect January 1, 2010 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 DC to host the 2012 International AIDS Conference.

HHS Health Resources and Services Administration (HRSA)

In October 2009, the 111th Congress passed and President Obama signed the Ryan White HIV/AIDS Treatment Extension Act of 2009 (S.1793, P.L. 111-87) (CARE Act), which reauthorizes the Ryan White program for four more years through September 30, 2013. In response to the domestic epidemic, the United States Congress provides funds to U.S. States, metropolitan areas, and local communities through the 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 Care Act of 2009 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.

HHS Centers for Disease Control and Prevention (CDC)
The ACT AGAINST AIDS, a 5-year national communication and mobilization campaign, was launched April 7, 2009. The goal of this initiative is to reduce HIV incidence through: a) refocusing attention on domestic HIV and AIDS and combating complacency, b) promoting awareness, targeted behavior change, and HIV testing, and c) strengthening and establishing networks, community leadership and engagement, and other partnerships to extend the reach and credibility of HIV prevention messages.

HHS National Institutes of Health (NIH)
On December 1, 2009 the "Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents" were revised. The revised guidelines recommend antiretroviral therapy for all HIV-infected patients with a history of an AIDS-defining illness or a $CD4^+$ T-cell count of <350 cells/mm^3. Antiretroviral treatment is also now recommended for patients with $CD4^+$ T-cell counts between 350 and 500 cells/mm^3. There are also now four "preferred" antiretroviral regimens treatment-naive patients.

HHS Substance Abuse and Mental Health Services Administration (SAMHSA)
SAMHSA has recently has expanded its program activities to include HIV and hepatitis testing in its substance abuse prevention and treatment facilities. The focus was to introduce and/or increase the number of HIV and hepatitis tests occurring in these facilities and to provide prevention and treatment services of these and other co-morbidities.

HHS Centers for Medicare & Medicaid Services (CMS)
In December 2009, CMS announced it will cover HIV infection screening for Medicare beneficiaries who are at increased risk for the infection, including women who are pregnant and Medicare beneficiaries of any age who voluntarily request the service. This marks a new direction of covering preventive services in Medicare.

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. Through PEPFAR, the U.S. Government has committed approximately $32 billion to bilateral HIV/AIDS programs, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, and bilateral TB programs through Fiscal Year (FY) 2010. The human impact of America's investments in partner nations' efforts is profound. PEPFAR has directly supported life-saving antiretroviral treatment for over 2.4 million men, women and children as of September 2009.

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/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 resulted in noteworthy scientific breakthroughs such as the landmark 2009 discovery of powerful antibodies that may be critical to blocking HIV.

(d) UNGASS indicator data in an overview table.

Core indicators for *Declaration of Commitment* Implementation

Generalized Epidemic Indicators

National Commitment and Action

1 – Domestic and international AIDS spending by categories and financing sources

HIV/AIDS

HHS HIV/AIDS Funding (by Agency)

(Dollars in millions)

	FY 2009 Enacted	FY 2009 ARRA	FY 2010 Enacted	FY 2011 Pres. Budget	FY 2011 +/- FY 2010 $	FY 2011 +/- FY 2010 %
By Agency:						
DISCRETIONARY:						
FDA	$96.8	--	$109.2	$111.2	+$2.0	+1.8%
HRSA:						
Ryan White	$2,238.4	--	$2,290.9	$2,330.4	+$39.5	+1.7%
Other HRSA	3.4	--	3.4	4.0	+0.6	+17.6%
Subtotal, HRSA	$2,241.8	--	$2,294.3	$2,334.4	+$40.1	+1.7%
IHS	$4.9	--	$5.0	$5.2	+$0.1	+3.0%
CDC	$850.7	--	$887.0	$916.6	+$29.7	+3.3%
International AIDS (non-add)	*$118.9*	--	*$119.0*	*$118.1*	*-$0.9*	*-0.7%*
NIH (excluding Global AIDS Fund) 1/	$3,019.3	318.7	$3,085.6	$3,184.3	+$98.7	+3.2%
International AIDS (non-add)	*$451.7*	*$15.7*	*$454.2*	*$470.6*	*+$16.5*	*+3.6%*
SAMHSA	$178.2	--	$178.5	$178.3	-$0.16	-0.09%
AHRQ	$2.8	--	$2.8	$1.4	-$1.40	-50.0%
OS:						
OS Health Offices	$10.2	--	$9.5	$9.8	+$0.3	+3.7%
Office for Civil Rights	0.3	--	0.3	0.4	+0.09	+27.3%
Minority Communities AIDS Projects	51.9	--	53.9	53.9	--	--
Subtotal, OS	$62.3	--	$63.7	$64.2	+$0.4	+0.7%
SUBTOTAL, Discretionary	**$6,456.9**	**$318.7**	**$6,626.1**	**$6,795.6**	**+$169.6**	**+2.6%**
Global AIDS Fund 1/	$300.0	--	$300.0	$300.0	--	--
SUBTOTAL, Discretionary	**$6,756.9**	**$318.7**	**$6,926.1**	**$7,095.6**	**+$169.6**	**+2.4%**
Domestic AIDS	*$5,886.4*	*$302.9*	*$6,052.9*	*$6,206.9*	*+$154.0*	*+2.54%*
International AIDS	*$870.6*	*$15.7*	*$873.1*	*$888.7*	*+$15.6*	*+1.8%*
ENTITLEMENT:						
CMS:						
Medicaid Estimate (Fed Share)	$4,400.0	--	$4,700.0	$5,100.0	+$400.0	+8.5%
Medicare Estimate	4,800.0	--	5,100.0	5,400.0	+300.0	+5.9%
SUBTOTAL, Entitlement	**$9,200.0**	--	**$9,800.0**	**$10,500.0**	**+$700.0**	**+7.1%**
TOTAL, HHS	**$15,956.9**	**$318.7**	**$16,726.1**	**$17,595.6**	**+$869.6**	**+5.2%**
Domestic AIDS	*$15,086.4*	*$302.9*	*$15,852.9*	*$16,706.9*	*+$854.0*	*+5.4%*
International AIDS	*$870.6*	*$15.7*	*$873.1*	*$888.7*	*+$15.6*	*+1.8%*

1/ While budgeted in NIH, HHS contributions to the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria are not reflected in the NIH HIV/AIDS spending figures, but are accounted for separately.

Minority AIDS Initiative

(Dollars in Millions)

	FY 2010	FY 2011	Increase / Decrease
CDC	96	96	--
HRSA	146	153	+7
SAMHSA	117	117	--
Minority HIV/AIDS Fund	54	54	--
OS (OMH/OWH)	9	9	--
Total MAI	**422**	**429**	**+7**

2 – National Composite Policy Index (areas covered: gender, workplace programs, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation).

PART A

I. STRATEGIC PLAN

1. Has the country developed a national multi-sectorial strategy to respond to HIV?

One of President Obama's top HIV/AIDS policy priorities is the development and implementation of a National HIV/AIDS Strategy (NHAS). To ensure the process to develop the NHAS is inclusive of a broad range of perspectives and stakeholders, the Office of National AIDS Policy (ONAP) in the White House Domestic Policy Council has engaged public involvement via multiple channels. The strategy, which will be completed in Spring 2010, will clearly describe the areas that require the most immediate change and the specific action steps that must be taken by the Federal Government and other HIV/AIDS stakeholders to meet three goals:

- Reducing HIV incidence;
- Increasing access to care and optimizing health outcomes; and
- Reducing HIV-related health disparities.

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Additionally, the United States has in place a national plan for HIV prevention developed by the Centers for Disease Control and Prevention (CDC).

1.2 *IF YES*, does the national strategy/action framework address the following areas, target populations and cross-cutting issues?

1.5 Has your country ensured "full involvement and participation" of civil society in the planning phase?

During the planning and development of the National HIV/AIDS Strategy the White House Office of National AIDS Policy created a web platform to solicit public comments, held town hall discussions across the country and permitted all Americans the opportunity to contribute ideas, suggestions and recommendation to the development of a National HIV/AIDS Strategy.

1.6 Has the national strategy/action framework been endorsed by key stakeholders?

Not applicable. The National HIV/AIDS Strategy is under development.

2. Has the country integrated HIV into its general development plans such as in: (a) National development plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; (d) sector-wide approach?
Not applicable.

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?
Not applicable.

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?
There are numerous programs for HIV/AIDS prevention, care and support, HIV testing and counseling for Americans regardless of their profession, military, or social status. For example, the Veterans Affairs Department offers routine HIV tests to veterans who receive medical care.

5. Does the country have non-discrimination laws or regulations with specific <u>protections</u> for most-at-risk populations or other vulnerable subpopulations?
The Americans with Disabilities Act (ADA) is a comprehensive disability anti-discrimination law, which includes HIV/AIDS as a disability and entitles protection regardless of symptoms or lack of symptoms (42 U.S.C. 12102, 42 U.S.C. 12112, 42 U.S.C. 12132, 42 U.S.C. 12182, 29 CFR 1630, 28 CFR 35.130, 28 CFR 36.201). In addition, the Rehabilitation Act prohibits discrimination on the basis of disability in programs conducted by Federal agencies, in program receiving Federal financial assistance, in Federal employment, and in the employment practices of Federal contractors (29 U.S.C. 791, 793, 794). The Fair Housing Act prohibits housing discrimination, including on the basis of disability (42 U.S.C. 802, 804, 805). Furthermore, federal civil rights laws and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, together protect all citizens fundamental rights of nondiscrimination and personal health information privacy. HIPAA attempts to address some of the barriers to healthcare coverage and related job mobility impediments facing people with HIV as well as other vulnerable populations.

The Department of Labor's Office of Federal Contract Compliance Programs administers and enforces three equal employment opportunity laws that apply to federal contractors and subcontractors: Executive Order (EO) 11246, as amended; Section 503 of the Rehabilitation Act of 1973, as amended; and the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (VEVRAA), as amended (38 U.S.C. 4212). These EEO laws prohibit Federal contractors and subcontractors from discriminating on the basis of race, color, religion, sex, national origin, or status as a qualified individual with a disability or protected veteran. OFCCP also shares responsibility with the U.S. Equal Employment Opportunity Commission in enforcing Title I of the Americans with Disabilities Act.

6. Does the country have laws, regulations or policies that present <u>obstacles</u> to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

The United States has a Federal system of Government. Programming for most-at-risk populations and other vulnerable subpopulations is dealt with at the federal, state, tribal and local level. In some states and municipalities there may be laws that prevent effective and comprehensive HIV prevention, care and support for some populations. Local policy-setting can both increase or decrease obstacles to successful outreach and are specific to communities. The National HIV/AIDS Strategy mentioned in Part A, Section 1, Question 1(1) will recommend ways to reduce obstacles at all levels.

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

The Ryan White Program, administered by HRSA, works with cities, states, and local community-based organizations to provide HIV-related services for those who do not have sufficient health care coverage or financial resources for coping with HIV disease. Ryan White fills gaps in care not covered by these other sources. Estimated to reach more than half a million people with HIV each year, this program contributes greatly to the United States coming as close as possible to universal access to prevention, care and treatment.

II. POLITICAL SUPPORT

1. Do high officials speak publicly and favorably about HIV efforts in major domestic forums at least twice a year?

The President, high federal government officials and officials in state government often speak publicly about HIV/AIDS. President Obama referenced the Administration's HIV/AIDS activities on several occasions in 2009, including making a video and being interviewed for National HIV Testing Day. The President publicly signed the Ryan White HIV and AIDS Treatment Extension Act of 2009 for domestic HIV care and treatment, and spoke at other venues, including remarks before the Human Rights Campaign. Additionally, White House officials, members of the Cabinet and the White House Office of National AIDS Policy Director, Jeffrey Crowley have publicly expressed support for those infected and affected by HIV/AIDS.

In addition to World AIDS Day (December 1), there are many other official HIV/AIDS awareness and observance days promoted in the U.S. which provide opportunities for official at all levels of government to speak publicly about HIV/AIDS. They include: National Black HIV/AIDS Awareness Day (February 7), National Women and Girls HIV/AIDS Awareness Day (March 10), National Native HIV/AIDS Awareness Day (March 20), HIV Vaccine Awareness Day (May 18), National Asian and Pacific Islander HIV/AIDS Awareness Day (May 19), Caribbean American HIV/AIDS Awareness Day (June 8), National HIV Testing Day (June 27), National HIV/AIDS Aging Awareness Day (September 18), National Gay Men's HIV/AIDS Awareness Day (September 27), and National Latino AIDS Awareness Day (October 15).

2. Does the country have an officially recognized national multi-sectorial AIDS coordination body (National AIDS Commission or equivalent)?

The Office of National AIDS Policy (ONAP), part of the White House Domestic Policy Council, coordinates the Federal government's ongoing efforts to reduce the number of new HIV infections in the United States. The Office emphasizes prevention through wide-ranging education initiatives, and helps coordinate the care and treatment of people with HIV/AIDS. The ONAP website appears here: http://www.whitehouse.gov/administration/eop/onap.

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programs?
Yes. The Presidential Advisory Council on HIV/AIDS (PACHA) is a multi-sectorial representative body that advises the Federal government on the nation's HIV/AIDS response and provides the public a forum for comment and engagement. The PACHA website appears here: http://www.pacha.gov. In addition, AIDS.gov provides comprehensive information on the Federal government's efforts in HIV prevention and care.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?
Data for this indicator is not available.

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?
The support encompasses, but is not limited to, financial support, technical assistance, guidance and standards for services.

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?
This effort is underway as part of the development of the National HIV/AIDS Strategy. Additionally, ONAP has commissioned the Institute of Medicine to conduct a series of analyses throughout 2010 that examine policies that are obstacles to HIV testing and care.

III. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?
The country has developed multiple venues for the dissemination of HIV/AIDS information; communication and education and the mediums are reviewed and revised often. For example, the CDC National Prevention Information Network (NPIN) is the U.S. reference and referral service for information on HIV/AIDS, viral hepatitis, sexually transmitted diseases (STDs), and tuberculosis (TB). NPIN collects, catalogs, processes, and electronically disseminates materials and information on HIV/AIDS, viral hepatitis, STDs, and TB to organizations and people working in those disease fields in international, national, state, and local settings.

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?
The United States has a Federal system of government under which setting curricula is the prerogative of state and local governments.

3. Does the country have a policy or strategy to promote information, education and communication and other prevention health interventions for most-at-risk or other vulnerable sub-populations?
See Part A, Section III, Question 1 above. Information, education and communication are available to all Americans, including most-at-risk or other vulnerable sub-populations. The Department of Labor's Occupational Safety and Health Administration (OSHA) also requires comprehensive protections to protect workers in healthcare from exposure to blood and other infectious materials. OSHA's Bloodborne Pathogens Standard provides additional protections, including post-exposure testing and prophylaxis.

4. Has the country identified specific needs for HIV prevention programs?
Yes.

4.1

HIV Prevention Component	**The majority of people in need have access**
Blood safety	Agree
Universal precautions in health care settings	Agree
Prevention of mother-to-child transmission of HIV	Agree
IEC on risk reduction	Agree
IEC on stigma and discrimination reduction	Agree
Condom promotion	Agree
HIV testing and counseling	Agree
Harm reduction for injection drug users	Agree
Risk reduction for men who have sex with men	Agree
Risk reduction for sex workers	Agree
Reproductive health services including sexually transmitted disease prevention and treatment	Agree
School-based HIV education for young people	Agree
HIV prevention for out of school young people	Agree
HIV prevention in the workplace	Agree

IV. TREATMENT, CARE AND SUPPORT

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counseling, psychosocial care, and home and community based care).
This effort is underway as part of the development of the National HIV/AIDS Strategy. The Ryan White Care Act is administered by the HHS Health Resources and Services Administration, HIV/AIDS Bureau. Federal funds are awarded to agencies located around the country, which in turn deliver care to eligible individuals under funding categories called Parts to meet needs for different communities and populations affected by HIV/AIDS. Also, CDC has recommendations in place for HIV testing "intended for all health-care providers in the public and private sectors, including those working in hospital emergency departments, urgent care clinics, inpatient services, substance abuse treatment clinics, public health clinics, community

clinics, correctional health-care facilities, and primary care settings. The recommendations address HIV testing in health-care settings only." Additionally, NIH periodically updates clinical Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Furthermore, the U.S. federal system delegates some of this authority to the states.

2. Has the country identified the specific needs for HIV treatment, care and support services?
Yes.

2.1

HIV treatment, care and support service	**The majority of people in need have access**
Antiretroviral therapy	Agree
Nutritional care	Agree
Pediatric AIDS treatment	Agree
Sexually transmitted infection management	Agree
Psychosocial support for people living with HIV and their families	Agree
Home-based care	Agree
Palliative care and treatment of common HIV-related infections	Agree
HIV testing and counseling for TB patients	Agree
TB screening for HIV-infected people	Agree
TB preventive therapy for HIV-infected people	Agree
TB infection control in HIV treatment and care facilities	Agree
Cotrimoxazole prophylaxis in HIV-infected people	Agree
Post-exposure phrophylizs (occupational exposure, rape, etc)	Agree
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree

2. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

The Food and Drug Administration (FDA) in the U.S. Department of Health and Human Services (HHS) has the mandate for the regulatory approval and licensure of generic drugs within the United States. An Abbreviated New Drug Application (ANDA) submitted to FDA's Center for Drug Evaluation and Research, Office of Generic Drugs, contains data which provides for the review and ultimate approval of a generic drug product. Once approved, an applicant may manufacture and market the generic drug product to provide a safe, effective, low cost alternative to the American public. Using bioequivalence as the basis for approving generic copies of drug products was established by the "Drug Price Competition and Patent Term Restoration Act of 1984[2]," also known as the Waxman-Hatch Act. This Act expedites the availability of less costly generic drugs by permitting FDA to approve applications to market generic versions of brand-name drugs without conducting costly and duplicative clinical trials, however the Waxman-Hatch Act only comes into affect after the innovator company's intellectual property rights expire. Additionally, in 1987, Congress enacted the Prescription Drug Marketing Act (PDMA) which established safeguards to prevent substandard, ineffective, or counterfeit drugs from entering the U.S. Under PDMA, it is illegal for anyone other than the drug's original

manufacturer to re-import a prescription drug into the U.S. that was manufactured in the U.S.

4. Does the country have access to regional procurement and supply management mechanism for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?

The Federal government has access to the Pan American Health Organization's (PAHO) Regional Revolving Fund for Strategic Public Health Supplies, a mechanism created to promote access to quality essential public health supplies in the Americas, and additionally, federal, state, and local entities have sufficient commodity procurement mechanisms and networks.

5. Dose the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?
The United States has a Federal system of government, under which individual states enact laws and promulgate regulations to protect the rights and interests of orphans and vulnerable children.

V. MONITORING and EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan?
There is no one national Monitoring and Evaluation plan; however, from 1982 to the present, there have been multiple M&E tools in place throughout the Federal government, primarily within the CDC. Also, CDC has developed Program Evaluation and Monitoring System (PEMS) to strengthen monitoring and evaluation of HIV prevention programs. PEMS is to be used by health departments and CBOs funded through CDC HIV prevention cooperative agreements.

2. Does the national Monitoring and Evaluation (M&E) plan include?

A data collection strategy?	Yes
A well-defined standardized set of indicators?	Yes
Guidelines on tools for data collections?	Yes
A strategy for assessing data quality (i.e. validity, reliability)?	Yes
A data analysis strategy?	Yes
A data dissemination and use strategy?	Yes

3. Is there a budget for implementation of the M&E plan?
There is an annual budget allocation.

4. Are M&E priorities determined through a national M&E system assessment?
No.

5. Is there a functional national M&E unit?
There is an M&E division and Monitoring and Evaluation Officers at the CDC .

6. Is there a national M&E committee or working group that meets regularly to coordinate M&E activities?
No.

7. Is there a central national database with HIV-related data?
No.

8. Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data?
No.

9. To what extent are M&E data used (low=0, high=5)?
Not applicable.

10. Is there a plan for increasing human capacity in M&E at national, sub national and service-delivery levels?
No.

PART B

I. HUMAN RIGHTS

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (Including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc)
See Part A, Section I, Question 5.

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?
Protections are afforded to all Americans regardless of risk and vulnerability status. See Part A, Section I, Question 5.

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?
See Part A, Section I, Question 6. The Federal government is working with state governments to address obstacles to effective HIV prevention, treatment, care and support.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?
For examples see Part A, Section I, Question 5.

5. Is there a mechanism to record, document and address cases of discrimination experience by people living with HIV, most-at-risk populations and/or other vulnerable populations?

The Department of Justice, Civil Rights Division, enforces Federal statutes designed to protect the civil rights of all individuals and prohibit discrimination, including on the basis of disability. The primary goal of the Disability Rights Section of that Division is to achieve equal opportunity

for people with disabilities, including those with HIV/AIDS, in the United States by implementing the Americans with Disabilities Act (ADA), and achieves that goal through enforcement, certification, regulatory, coordination, and technical assistance activities. The Housing and Civil Enforcement Section of that Division enforces the Fair Housing Act, which prohibits discrimination in housing, including against persons with disabilities. Several other federal agencies play specific roles in enforcing federal civil rights laws. The Equal Employment Opportunity Commission investigates and enforces employment discrimination laws. The Office of Fair Housing and Equal Opportunity in the Department of Housing and Urban Development administers and enforces federal laws related to housing discrimination. The Office of Civil Rights in the Department of Education ensures equal access to education and promotes education excellence through enforcement of discrimination laws in the education context. The Office for Civil Rights (OCR) within the Department of Health and Human Services is another entity for civil rights and health privacy law enforcement, OCR investigates complaints, enforces rights, and promulgates regulations, develops policy and provides technical assistance and public education to ensure understanding of and compliance with non-discrimination and health information privacy laws. Federal civil rights laws and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, together protect fundamental rights of nondiscrimination and health information privacy.

Further, the Department of Labor's Office of Federal Contract Compliance Programs has specific policies under Section 503 regulations concerning HIV/AIDS and related conditions guidelines for processing and investigating complaints filed by or on behalf of persons with HIV/AIDS and related conditions.

6. Has the government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and program implementation?
The U.S. has over 50 groups who represent vulnerable populations. Each of these organizations is involved in policy design and implementation. There are also U.S. state-level groups (HIV Care and Treatment Consortiums and eligible Metropolitan-Area HIV-Planning Councils) and local groups (Community HIV-Prevention Planning Groups) that participate in policy planning and program implementation with the Federal Government. There are Federal requirements for the participation of people living with HIV in these planning bodies. Further, CDC and HRSA invest significant resources in training and technical assistance on parity, inclusion, and representation of people living with HIV in policy making processes. There are eight openly HIV-positive members on the Presidential Advisory Council on HIV/AIDS, as well as HIV-positive staff in ONAP and at the Office of the Global AIDS Coordinator.

7. Does the country have a policy of free services for the following:

7a. HIV prevention services
The majority of HIV prevention services including education, IEC, and condom distribution are publicly funded and are often free or at reduced cost.

7b. antiretroviral therapy AND **7c. HIV-related care and support intervention**
The AIDS Drug Assistance Program (ADAP) provides medications for the treatment of

HIV disease. Program funds may also be used to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of drug treatments. The program is funded through Part B of the Ryan White HIV/AIDS Treatment Modernization Act (formerly known as the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act) which provides grants to States and Territories. Other publicly funded services through Medicare and Medicaid are also available.

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?
All Americans have equal access under the law.

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV preventions, treatment, care and support?
All Americans have equal access under the law.

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Under Federal disability and non-discrimination laws, employers are prohibited from making disability-related inquiries or requiring medical examinations of individuals pre-job offer. So it would be impermissible to require that applicants undergo HIV testing. Employers may, however, make pre-employment inquiries into the ability of an applicant to perform job-related functions, and/or may ask an applicant to describe or to demonstrate how, with or without reasonable accommodation, the applicant will be able to perform the essential functions of the job.

Employers may also require a medical examination or make a disability-related inquiry AFTER making an offer of employment but before the applicant begins his duties, and may condition the employment offer on the results of such inquiry or examination, IF all entering employees into the same job category are subjected to such examination or inquiry, regardless of disability. However, if the job offer is later withdrawn based on the disability-related information received, the employer must show that the basis for its decision to withdraw the offer is job-related and consistent with business necessity. In addition, the employer may require a medical examination or make an inquiry of a current employee if the examination or inquiry is job-related and consistent with business necessity. Generally, a disability-related inquiry or medical examination of an employee may be "job-related and consistent with business necessity" when an employer "has a reasonable belief, based on objective evidence, that: (1) an employee's ability to perform essential job functions will be impaired by a medical condition; or (2) an employee will pose a direct threat due to a medical condition."

Several laws enforced by DOL extend this protection to individuals with disabilities: Section 503 (Federal contractor context) and 504 of the Rehabilitation Act (DOL-conducted programs and federally-financed programs), Section 188 of WIA (programs financed via Title I of WIA), and VEVRAA (Federal contractors).

11. Does the country have a policy to ensure that HIV research protocols involving human

subjects are reviewed and approved by a national/local ethical review committee?
The HHS Office for Human Research Protections ensures research protocols involving human subjects are reviewed and approved through the Institutional Review Boards (IRB) process. Risks to research subjects posed by participation in research should be justified by the anticipated benefits to the subjects or society. This requirement is clearly stated in all codes of research ethics, and is central to the federal regulations. One of the major responsibilities of the IRB, therefore, is to assess the risks and benefits of proposed research. In the United States, regulations protecting human subjects first became effective on May 30, 1974. Promulgated by the Department of Health, Education and Welfare (DHEW), those regulations raised to regulatory status NIH's Policies for the Protection of Human Subjects, which were first issued in 1966. The regulations established the IRB as one mechanism through which human subjects would be protected. There is also specific IRB guidance for AIDS studies.

12. Does the country have the following human rights monitoring and enforcement mechanisms?

- Existence of independent national institutions for the promotions and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudsperson which consider HIV-related issues within their work
The U.S. Commission on Civil Rights and its 51 State Advisory Committees perform some of these functions.

- Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment
The Department of Justice, Civil Rights Division, enforces federal statutes designed to protect the civil rights of all individuals and prohibit discrimination, including on the basis of disability. The primary goal of the Disability Rights Section of that Division is to achieve equal opportunity for people with disabilities, including those with HIV/AIDS, in the United States by implementing the Americans with Disabilities Act (ADA), and achieves that goal through enforcement, certification, regulatory, coordination, and technical assistance activities. The Housing and Civil Enforcement Section of that Division enforces the Fair Housing Act, which prohibits discrimination in housing, including against persons with disabilities. Several other federal agencies play specific roles in enforcing federal civil rights laws. The Equal Employment Opportunity Commission investigates and enforces employment discrimination laws. The Office of Fair Housing and Equal Opportunity in the Department of Housing and Urban Development administers and enforces federal laws related to housing discrimination. The Office of Civil Rights in the Department of Education ensures equal access to education and promotes education excellence through enforcement of discrimination laws in the education context. The Office for Civil Rights in the Department of Health and Human Services protects against discrimination and health privacy violations in the context of the provision of healthcare.

- Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts
With respect to complaints where jurisdiction has been established by the Department of

Labor's Office of Federal Contract Compliance Programs (OFCCP), OFCCP will accept, process and investigate complaints alleging discrimination based on all HIV-related conditions. In order to establish that a complaint alleging discrimination based on an HIV-related condition is covered by OFCCP's Section 503 regulations, it is necessary to show (1) that the person had a substantially limiting impairment, and (2) that the person's condition did not pose a direct health or safety threat or prevent successful job performance.

13. In the last 2 years, have members of the judiciary (including labor courts/employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?
No.

14. Are the following legal support services available in the country?

- Legal aid systems for HIV casework?
Yes.

- Private sector law firms or university-based centers to provide free or reduced-cost legal services to people living with HIV?
Yes.

- Programs to educate, raise awareness among people living with HIV concerning their rights?
Yes.

15. Are there program in place to reduce HIV-related stigma and discrimination?
Yes.

II. CIVIL SOCIETY

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations (low=0, high=5)?
High, 5

2. To what extent have civil society representative been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (eg. Attending planning meetings and reviewing drafts) (low=0, high=5)?
Mid, 3

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in
a. National AIDS strategy (low=0, high=5)? Not applicable.
b. national AIDS budget (low=0, high=5)? Not applicable.
c. national AIDS reports (low=0, high=5)? Not applicable.

4. To what extent is civil society included in monitoring and evaluation of the HIV

response?
The Presidential Advisory Council on HIV/AIDS (PACHA) will be responsible for monitoring and evaluation of the National HIV/AIDS Strategy.

a. developing the national M&E plan (low=0, high=5)? Not applicable.
b. participating in the national M&E committee/working group responsible for coordination of M&E activities (low=0, high=5)? Not applicable.
c. M&E efforts at local level? Not applicable.

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (eg. Networks of people living with HIV, organizations of sex workers, faith-based organizations) (low=0, high=5)?
High, 5

6. To what extent is civil society able to access:
a. adequate financial support to implement its HIV activities (low=0, high=4)?
Mid, 3
b. adequate technical support to implement its HIV activities (low=0, high=5)?
High, 4

7. What percentage of the following HIV programs/services is estimated to be provided by civil society?
Data for this are not available.

Prevention for youth	<25%	25-50%	51-75%	>75%
Prevention for IDU	<25%	25-50%	51-75%	>75%
Prevention for MSM	<25%	25-50%	51-75%	>75%
Prevention for sex workers	<25%	25-50%	51-75%	>75%
Testing and counseling	<25%	25-50%	51-75%	>75%
Reduction of stigma and discrimination	<25%	25-50%	51-75%	>75%
Clinical services (ART/OI)	<25%	25-50%	51-75%	>75%
Home-based care	<25%	25-50%	51-75%	>75%
Programs for OVC	<25%	25-50%	51-75%	>75%

III. PREVENTION

1. Has the country identified the specific needs for HIV prevention programs?
1.1

HIV Prevention Component	**The majority of people in need have access (agree, don't agree, N/A)**
Blood safety	Agree
Universal precautions in health care settings	Agree
Prevention of mother-to-child transmission of HIV	Agree
IEC on risk reduction	Agree

IEC on stigma and discrimination reduction	Agree
Condom promotion	Agree
HIV testing and counseling	Agree
Harm reduction for injection drug users	Agree
Risk reduction for men who have sex with men	Agree
Risk reduction for sex workers	Agree
Reproductive health services including sexually transmitted prevention and treatment	Agree
School-based HIV education for young people	Agree
HIV prevention for out of school young people	Agree
HIV prevention in the workplace	Agree

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

There is a federal system in the United States, which allows individual states to enact laws to protect the rights and interests of orphans and vulnerable children.

National Programs

3 – Percentage of donated blood units screened for HIV in a quality assured manner.

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 are screened for HIV.

4 – Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.

Data for this indicator are not yet available.

In the future, this indicator will be measured by CDC's Medical Monitoring Project (MMP), a new, national population-based surveillance project that will collect information on clinical outcomes and behaviors of HIV-infected persons receiving care in the United States. Collection of data from interviews with HIV-infected patients will provide information on the current levels of behaviors that may facilitate HIV transmission; patients' access to, use of, and barriers to HIV-related secondary prevention services; utilization of HIV-related medical services; and adherence to drug regimens.

5 – Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission.

We do not have data to match this exact indicator.

In 2007, there were an estimated 139 cases of perinatally acquired HIV diagnosed in the 34 states and dependent areas of the United States with mature HIV surveillance systems. This was down from an estimated 177 in 2004.

Source: HIV/AIDS Surveillance Report, CDC, Vol. 17, Table 1, Estimated numbers of cases of HIV/AIDS, by year of diagnosis and selected characteristics, 2004-2007 – 34 states and U.S. dependent areas with confidential name-based HIV infection reporting.

6 – Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV.

We do not have data to match this exact indicator.

According to CDC's National TB Indicators Project, 74.4% of TB cases had a positive or negative HIV test result reported in 2009, and 7.6% of these cases had a positive HIV test result.

Source: National TB Indicators Project (NTIP). CDC. Reported February 25, 2010.

7 – Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results.

We do not have data to match this exact indicator.

The National Health Interview Survey (NHIS) gathers data on the percentage of women and men 18 years of age and older who have ever been tested for HIV (outside of blood donation) (2008):

Women:	Age-adjusted 42.3% (SE 0.45) Crude 40.9
Men:	Age-adjusted 37.1% (SE 0.49) Crude 36.6

Source: NHIS is the principal source of information on the health of the civilian noninstitutionalized population of the United States. NHIS data are used widely throughout the Department of Health and Human Services (DHHS) to monitor trends in illness and disability and to track progress toward achieving national health objectives.

Pleis JR, Lucas JW, Ward BW. Summary health statistics for U.S. adults: National health interview survey, 2008. National Center for Health Statistics. Vital Health Stat 10(242). 2009.

The National Survey of Family Growth (NSFG) gathers data on the percentage of 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:	15.9% (width of 95% CI=1.0)
Men:	14.2% (width of 95% CI=1.4)

Source: The NSFG gathers information on family life, marriage and divorce, pregnancy, infertility, use of contraception, and men's and women's health. Anderson JE, Chandra A,

Mosher WD. 2005. HIV Testing in the United States, 2002. Tables 2 and 3. Advance Data Number 363. Hyattsville, MD: National Center for Health Statistics.

8 – 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% of men who have sex with men (MSM) had been tested and received their results, and 66% of injection drug users had been tested for HIV.

Source. The NHBS is currently conducted in 23 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, and the 2005 cycle of NHBS that was conducted in 23 metropolitan areas. The next cycle will address high risk heterosexuals.

9 – Percentage of most-at-risk populations reached with HIV prevention programs.

According to data from NHBS, in 2004, 19% of MSM were reached with HIV prevention programs, and in 2005, 29% of injection drug users had been reached with prevention programs.

10 – Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child.

Data for this indicator are not available.

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

The Centers for Disease Control's (CDC) School Health Policies and Programs Study 2006 provides the following related data:

48.6% of school districts require the teaching of HIV prevention in elementary schools, 79.0% in middle schools, and 89.3% in high schools.

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 in middle school and 2.2 hours in high school.

Source: The School Health Policies and Programs Study (SHPPS) is a national survey periodically conducted to assess school health policies and practices at the state, district, school, and classroom levels. SHPPS was most recently conducted in 2006. SHPPS also was conducted in 2000 and 1994; the next SHPPS is planned for 2012.

Knowledge and Behavior

12 – Current school attendance among orphans and among non-orphans aged 10-14.

Data for this indicator are not available.

13 – Percentage of young women and men aged 15-24 who both correctly identify 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:
According to data gathered from the 2007 Youth Risk Behavior Surveillance System (YRBSS), 89.5% of students in grades 9-12 report having ever been taught about AIDS or HIV infection in school.

Source: The YRBSS monitors six categories of priority health-risk behaviors among youth and young adults. It includes a national school-based survey conducted by CDC, and state and local school-based surveys conducted by state and local education and health agencies. This report summarizes results from the national survey, 39 state surveys, and 22 local surveys conducted among students in grades 9–12 during January-December 2007.

Table 67, Youth Risk Behavior Surveillance – United States, 2007. CDC.

14 – Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

Data for this indicator are not available.

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

According to 2002 NSFG data:

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

Source: Teenagers in the United States: Sexual Activity Contraceptive Use, and Childbearing, 2002. Centers for Disease Control and Prevention, National Center for Heath 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.

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

Source: *Table 44, Youth Risk Behavior Surveillance – United States, 2005. CDC.*

16 – Percentage of women and men aged 15-49 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% had 2 or more sexual partners in the last year
Men:	17.0% had 2 or more sexual partners in the last year

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.

Fryar CD, Hirsch R, Porter KS, Kottiri B, Brody DJ, Louis T. Drug use and sexual behaviors reported by adults: United States, 1999–2002. Advance data from vital and health statistics; no. 384. Hyattsville, MD: National Center for Health Statistics, 2007.

Additional Data:
NSFG gathers data on the percentage of unmarried women and men aged 15-44 who have had sexual intercourse with more than 1 partner in the last 12 months:

Women:	17.4% (from Table 43 in Series 23 #25)
Men:	25.3% (from Table 23 in Series 23 #26)

Source: Chandra A, Martinez GM, Mosher WD, Abma JC, Jones J. 2005. Fertility, Family Planning, and Reproductive Health of U.S. Women: Data from the 2002 National Survey of Family Growth. Vital and Health Statistics. Series 23, Number 25. December, 2005. Hyattsville, MD: National Center for Health Statistics.

Source: Martinez GM, Chandra A, Abma JC, Jones J, and Mosher WD. 2006. Fertility, Contraception, and Fatherhood: Data on Men and Women from the 2002 National Survey of Family Growth. Vital and Health Statistics. Series 23, Number 26. May, 2006. Hyattsville, MD: National Center for Health Statistics.

17 – 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% (se=1.3)
Men:	42.2% (se=1.6)

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

According to NHBS data (which is limited to casual partners only, as opposed to steady partners), 76% of men who had receptive anal sex at last intercourse with a male casual partner had protected sex.

20 – Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse.

According to NHBS data from 2005, 63% of injection drug users had had unprotected vaginal sex within the previous 12 months

21 – Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected.

According to NHBS data from 2005, 59% of injections drug users had shared injection equipment in the previous 12 months and 33% had shared syringes within the previous 12 months.

Impact

22 – Percentage of young women and men aged 15-24 who are HIV infected.

An estimated 56,500 young women and men aged 13-24 were living with HIV in 2006.

Source: CDC. HIV prevalence estimates – United States, 2006.MMWR 2008;57:1073-1076

23 – Percentage of most-at-risk populations who are HIV-infected.

Data for this indicator are not available, as denominators for some populations (e.g., MSM) have not been developed to date.

24 – 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 CDC's Medical Monitoring Project (MMP).

25 – Percentage of infants born to HIV-infected mothers who are infected.

We do not have data to match this exact indicator.

In 2007, there were an estimated 139 cases of perinatally acquired HIV diagnosed in the 34 states and dependent areas of the United States with mature HIV surveillance systems. This was down from an estimated 177 in 2004.

Source: HIV/AIDS Surveillance Report, CDC, Vol. 17, Table 1, Estimated numbers of cases of HIV/AIDS, by year of diagnosis and selected characteristics, 2004-2007 – 34 states and U.S. dependent areas with confidential name-based HIV infection reporting.

III. Overview of the AIDS Epidemic

HHS/CDC's 2007 *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 2006 to 2007, the total number of new HIV/AIDS cases in the 33 states increased slightly from 38,531 to 44,084.

By transmission category, MSM remained the most heavily affected group, accounting for 53 percent (28,700) of people living with HIV infections in 2006. CDC's historical trend analysis indicates that HIV incidence has been increasing steadily among gay and bisexual men since the early 1990s, confirming a trend suggested by other data showing increases in risk behavior, sexually transmitted diseases (STDs), and HIV diagnoses in this population. Individuals infected through high-risk heterosexual contact comprised 31 percent (16,800). The historical analysis suggests that the number of new infections in this population fluctuated somewhat throughout the 1990s and has declined in recent years. Those infected through injection-drug use accounted for 12 percent (6,600) of the U.S. HIV-positive population. CDC's historical trend analysis indicates that new infections have declined dramatically in this population; between 1988-90 and 2003-06, HIV infections among injection drug users declined 80%. These declines confirm the success in reducing HIV infections among injection drug users. Although roughly three-quarters (74 percent) of Americans estimated to be living with HIV are male, the epidemic is increasingly affecting women (HHS/CDC, 2008).

HIV continues to have the greatest prevalence in the United States among African Americans and men who have sex with men (MSM)[1]. At the end of 2006, blacks accounted for 45 percent (24,900) of people estimated to be living with HIV in the U.S., whites accounted for 35 (19,600) percent, and Hispanics for 17 percent (9,700).

Geographically, the distribution of AIDS diagnosis rates per 100,000 for adults and adolescents in 2007 was highest in metropolitan areas with a population of more than 500,000. Southern States (Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia) experienced the highest burden of disease, followed by the Northeast,

[1] See Part B, Section III, Question 23 for information on percentage data.

West and Midwest.

IV. National Response to the AIDS Epidemic

For information on the process to develop President Obama's NHAS, see Part A, Section I, Question 1.

Additional response mechanisms include the following:

- **The Presidential Advisory Council on HIV/AIDS**: The Presidential Advisory Council on HIV/AIDS (PACHA) provides advice to the President, transmitted through the Secretary of Health and Human Services. PACHA's revised charter calls for the council to provide advice, information, and recommendations regarding programs and policies that address the three goals for the NHAS. In addition, PACHA will be instrumental in monitoring the implementation of the NHAS once the Strategy has been completed. Finally, PACHA will focus on the global HIV pandemic, including expanded access to treatment, care, and prevention for people infected with and affected by HIV/AIDS around the world. The Secretary of Health and Human Services is responsible for appointing individuals who serve on PACHA. PACHA membership has historically included prominent community leaders with particular expertise in, or knowledge of, matters concerning HIV and AIDS, public health, global health, philanthropy, marketing or business, as well as other national leaders held in high esteem from other sectors of society.

- **National HIV/AIDS Community Discussions**: ONAP held a series of fourteen forums from late summer through the end of 2009 in various regions of the country with diverse communities impacted by HIV/AIDS. These forums provided opportunities for individual citizens to provide White House staff and other policy makers with their recommendations for achieving the President's three goals for the NHAS. Locations for the planned forums include (in alphabetical order): Albuquerque, NM; Atlanta, GA; Columbia, SC; Fort Lauderdale, FL; Houston, TX; Jackson, MS; Los Angeles, CA; Minneapolis, MN; New York, NY; Oakland, CA; San Francisco, CA; Caguas, Puerto Rico; the Virgin Islands, and Washington, DC.

- **Call to Action: America Speaks about HIV/AIDS**: On October 2nd, 2009 ONAP launched a call to action to encourage community-based organizations, churches, schools, businesses, research institutions and other groups to hold their own discussions about the strategic steps we need to take as a nation to respond to the HIV/AIDS epidemic. The Call to Action comment form closed on November 23, 2009.

- **Interagency HIV/AIDS Working Group**: An interagency federal working group was convened and will be responsible for helping to develop the NHAS and ensuring coordination, accountability, and improved outcomes across the federal government. The interagency group includes representatives of other White House offices and agencies working on HIV/AIDS from across the federal government. ONAP recently announced the interagency members and process (see more information at

http://www.whitehouse.gov/blog/2010/02/22/onap-announces-federal-interagency-members-developing-national-hivaids-strategy)

V. Best Practices

During this reporting period the United States continues to support prevention and treatment research in order to reduce HIV incidence, improve disease outcomes and reduce HIV related disparities. Below are several key elements the U.S. has found to hold the most promise in addressing the epidemic.

- **Expanding access to HIV testing and co-locating testing, medical care and social services.** Expanding testing and effectively linking to services is essential in reducing HIV transmission. Many people living with HIV/AIDS who are aware of their status are not currently accessing care and treatment services. Linking diagnosed positives to care may increase individual health outcomes and community awareness. This concept of testing and treating is currently being investigated in Washington, DC and Bronx, NY.

- **Encouraging service integration and promoting effective collaborations to facilitate integrated and comprehensive HIV/AIDS response.** Collaborative efforts make it possible to share best practices, communicate lessons learned, expand access, reduce duplication of efforts and maximize use of existing resources.

- **Enhancing cultural competency skills of service providers.** Throughout the nation, a growing consensus is emerging about the nature and importance of cultural competence as an essential component of accessible, responsive, and high quality health care.

- **Utilization of new media and information technologies.** New media, electronic health and medical records and other forms of electronic technologies are providing access to information and resources through a variety of previously unexplored channels.

VI. Major Challenges and Remedial Actions

(a) progress made on key challenges reported in the 2007/2008 UNGASS Country Progress Report, if any;

The U.S. Government is continuing to address the challenges identified in the United States submission of the 2007/2008 UNGASS Country Progress Report. We have made significant progress on improving surveillance systems, increasing access to HIV/AIDS care and treatment, and supporting most-at-risk populations. For examples see Part B, Section VIII, Questions A; Part A, Section I, Question 7; and Part A, Section III, Question 1 and 3.

(b) challenges faced throughout the reporting period (2008-2009) that hindered the national response, in general, and the progress towards achieving the UNGASS targets, in particular; and,

In some states, prevention efforts are underfunded, in part because of budget constraints, and in part because of the priority placed on treatment and care. Additionally, funding for the AIDS Drug Assistance Program (ADAP), a national program initiated by the U.S. government in 1987 through the Ryan White Care Act to provide free or low cost drugs to people with HIV who have limited financial resources, is insufficient to meet demand, resulting in nearly 500 clients in need of drug assistance on a waiting list.

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

A National HIV/AIDS Strategy is currently under development. (see Part A, Section I, Question 1).

VII. Support from the Country's Development Partners

N/A

VIII. Monitoring and Evaluation Environment

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

CDC is responsible for monitoring the HIV/AIDS epidemic in the United States. Each year, the 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.

(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. There are still varied means of case reporting by state, with some using name-based and others code-based, therefore not all states contribute to national surveillance reports. Other challenges exist in potential underreporting, duplicate reporting or reporting variances across agencies leading to inaccurate counts.

(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

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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