

**MOVING BEYOND THE STATUS QUO:
IMPROVING OUTCOMES THROUGH A NATIONAL HIV/AIDS STRATEGY
IN THE UNITED STATES**

February 24, 2010

For the past two years, many advocates in the United States have been working for the development and implementation of a National Strategy to guide our response to the HIV epidemic. This document presents a vision for the framework of the National HIV/AIDS Strategy. It describes the key components that the Strategy should include, how it might be structured, and what elements are most critical to meet the primary goals identified by the President: reduce HIV incidence, increase care access, and decrease HIV-related health disparities.

To be successful, the National HIV/AIDS Strategy must challenge the status quo and identify a limited set of policy and management initiatives that can result in measurable impact. In this case, an exhaustive litany of efforts relevant to HIV/AIDS mitigation is unwarranted. The Strategy must avoid the shortfalls of many past planning efforts that, by making extensive lists of potential actions in multiple areas, essentially established no priorities. By identifying activities that can have the highest impact in clear and simple terms, the Strategy can mobilize not only government decision-makers but other sectors and constituencies at the national, state and local level whose support will be essential in moving the plan forward.

The Strategy must be relevant and actionable for the White House, relevant federal agencies, Congress, the private sector, and the general public. It must underscore the enormous potential to reverse HIV trends; it must galvanize people affected by HIV/AIDS and allies to assure action on the Strategy's core components and recommendations. It must describe specific activities necessary to reach hard-hit populations. It must acknowledge the economic, social, and humanitarian toll of not pursuing a strategic plan of action by including a description of the new infections, deaths, health and human service expenditures, and lost productivity expected unless action is taken immediately to slow the epidemic.

A meaningful Strategy requires that:

- ❖ **Members of the Interagency Group** developing and implementing the Strategy put the President's goals before agency interests and identify changes in programming and management to accomplish Strategy goals;
- ❖ **Community perspectives**, including those of populations most at risk and those of people living with HIV/AIDS (PLWHA), inform the development and implementation of the Strategy;
- ❖ **Congressional leaders** act on needed changes in law and policy to implement a more strategic effort and provide increased and targeted resources for this work;
- ❖ **The President, his Office of National AIDS Policy (ONAP), and the President's Advisory Council on HIV/AIDS (PACHA)** provide ongoing oversight of Strategy development and implementation; and,
- ❖ **Community providers and advocates** modify their work as necessary to focus public and private efforts on achieving improved outcomes.

Below are four recommended elements for incorporation into the Strategy, including specific suggestions for actionable steps to make progress against the HIV/AIDS epidemic in the U.S.

1. Set a Few Ambitious, Achievable Targets: To give the federal HIV/AIDS response focus, direction, and resolve, the Strategy must establish a limited number of specific targets.

A limited number of bold targets will focus the efforts of policymakers and implementers in and outside the government on achieving specific, priority outcomes to advance the fight against HIV/AIDS. With specific targets, federal officials can demand greater collaboration among agencies to achieve the Strategy goals. A focus on targets will draw attention to the progress made as well as areas needing improvement.

The Strategy's measurable targets must be relevant, inspiring, and easy to communicate.

The Strategy should establish targets within each of the three primary outcome areas established by the President. Regular assessment and monitoring toward each specific target is essential in ensuring the nation makes steady progress in achieving each objective.

EXAMPLE

With an aggressive and adequately funded Strategy, HIV/AIDS in the U.S. will stabilize by 2016 at approximately 1.37 million people living with HIV, 85% of whom will know their HIV status, have access to a defined and acceptable standard of care, and achieve optimal health outcomes. By 2021, new infections will not exceed 25,000 cases annually and deaths among people with HIV/AIDS will also remain stable at approximately 25,000 or fewer cases per year.¹

- ❖ Reductions in HIV incidence:
 - Annual HIV infections will drop to 32,000 by 2016 and to 25,000 by 2021. (The 2016 number represents a 50% reduction of estimated incidence in 2010, see appendix B.)
 - The HIV transmission rate will be approximately 2% to 2.5% by 2016.
- ❖ Increases in HIV care access:
 - Deaths among PLWHA will not exceed 25,000 annually by 2016.
 - 85% of PLWHA will know their HIV status, gain access to standard of care services, and achieve optimal health outcomes by 2016.
 - By 2016, fewer than 7,000 people will be diagnosed per year with AIDS in the 12 months after receiving an HIV diagnosis.
- ❖ Reductions in HIV health disparities:
 - By 2016, annual HIV incidence among people of color (POC) will be reduced by 55-60%.
 - By 2016, annual incidence among men who have sex with men (MSM) of all races will be reduced 55-60%, with the reduction in infections among Black and Latino MSM constituting at least half of the achieved reductions.
 - By 2016, no sub-population of PLWHA experiences death rates more than 5% above the HIV national average.
 - Beyond its national targets, the federal government will establish explicit numerical targets by race/ethnicity, mode of transmission, age, gender, sexual orientation, and region for each goal of the Strategy.

¹ See page 8 for appendix with definitions, assumptions, and indicators for tracking and monitoring targets

2. Improve federal management of HIV-related activities: To establish clear authority and responsibility for meeting targets, the Strategy must establish centralized management of the response through a *domestic equivalent* of the President's Emergency Plan for AIDS Relief.

The domestic response to HIV/AIDS requires high-level centralized management to achieve needed improvements in coordination, accountability and more efficient use of resources. One specific federal entity must be held responsible for reporting annually the progress made toward the targets. Annual reporting may require improved coordination and standardization of data elements, in addition to expanded data gathering in several areas. Our country's work to address the global epidemic provides valuable lessons that must inform a more effective and accountable domestic effort.

EXAMPLE

The federal government shall establish high-level centralized coordination of domestic HIV/AIDS efforts, similar to the model of the Office of the Global AIDS Coordinator (OGAC). The domestic HIV/AIDS coordinating office must be granted sufficient stature and authority to achieve cooperation among various federal agencies and departments. Authority for domestic HIV/AIDS coordination might be established in the Office of the Secretary in the U.S. Department of Health and Human Services or at the White House Office of National AIDS Policy.

OGAC is able to coordinate work across agencies and—of central importance—has budget authority over global AIDS efforts across multiple agencies and offices of the government. By granting the domestic coordinating entity some degree of budget authority (and/or budget transfer authority), it would be well positioned to promote coordination and collaboration, dedicate resources where they can have the greatest impact, and keep the entire effort focused on achieving progress on the Strategy's primary goals and targets. Duties of the domestic coordinating office shall include:

- ❖ Assuring integrated, cross-agency planning and coordination to maximize the impact of HIV/AIDS resources on implementing the Strategy.
- ❖ Using limited budget transfer authority to improve collaboration and dedicate resources on priority (or particularly successful) projects.
- ❖ Monitoring local and state prevention plans to ensure they are consistent with the epidemic profile and designed and scaled to reduce incidence.
- ❖ Creating one database system that is accessible to local health departments and funded agencies.
- ❖ Dedicating increased resources and spearheading coordinated prevention/treatment initiatives in particularly high-incidence areas or among high-incidence populations.
- ❖ Performing annual audits of prevention, treatment and research efforts across agencies to determine how they can be better aligned with achieving the three primary Strategy goals and corresponding targets.
- ❖ Ensuring a diverse health care and service provider workforce is in place to provide necessary and specialized HIV services.
- ❖ Issuing reports on prevention and treatment priorities for improved outcomes among particular groups heavily affected by HIV/AIDS.
- ❖ Informing the research agenda at NIH and other research agencies regarding research priorities of funding and implementing agencies.
- ❖ Reporting annually on: (1) progress towards Strategy targets, and, (2) policy changes and improved coordination efforts designed to achieve Strategy goals.

Without more centralized management of the domestic HIV/AIDS response there is the very real danger that federal agencies will have insufficient incentives to share resources, integrate activities, and collaborate toward the achievement of established national targets. The legacy of uncoordinated, largely patchwork approaches to HIV/AIDS programming will simply continue without structural reform in the management of federal AIDS activities.

In the event a coordinating authority is not created, it is essential that the federal agencies with primary responsibility for the HIV/AIDS response be mandated to report annually on how specifically they have changed policy, programming and management to achieve better outcomes and meet targets.

3. Priority activities: To achieve goals in the three priority areas, the Strategy must identify high-yield activities and strategic allocation of resources.

The core recommendations of the Strategy must be specific, measurable and tied to both the Strategy's goals and targets. They must be informed by evidence and delivered at a scale sufficient to demonstrate measurable population-level impact. They must be evaluated carefully in execution and implementation to make mid-course-corrections as needed. We recognize the Strategy will not address every aspect of the domestic HIV/AIDS response, but rather identify key initiatives and changes that can make the entire system more effective. In that spirit of identifying "game changing" approaches, below we make ten recommendations for priority activities.

Accomplishment of the President's Strategy goals will require new resources, scale up of what works, and more strategic use of current resources. It is important to note that in nearly all of our recommendations *we are not simply asking for more resources, but rather better targeting of resources, new approaches, and reformed efforts* to use current and new financing more effectively.

EXAMPLES OF PRIORITY ACTIVITIES

- a) **Implement a comprehensive anti-stigma and anti-discrimination initiative:** Stigma has been shown to play a significant role in inhibiting access to HIV testing and care, both among individual clients and their providers. In addition, stigma fuels HIV-related discrimination. It encourages opposition to evidence-based interventions for those at elevated risk (including syringe exchange and promotion of condom use). We recommend the federal government implement an ongoing campaign focused on reducing stigma against PLWHA and groups perceived to be at elevated risk of HIV. The initiative must include visible leadership from the President and other key leaders working closely with openly HIV-positive individuals to speak out against HIV-related discrimination. With his words and deeds, the President and other visible leaders can model non-stigmatizing behaviors for the nation. The President should also reach out to the faith community to encourage their engagement on the issue. The anti-stigma initiative should include legal reforms to undo laws that reinforce stigma, including, but not limited to, repeal of federal and state laws, and law enforcement practices, that criminalize the behavior of people living with HIV/AIDS; and reform of sentencing laws and creation of more options to avoid imprisonment to reduce overall levels of incarceration. There should be expansion of school interventions that promote acceptance of LGBT youth and scale up of community-level interventions encouraging families to accept their LGBT children.
- b) **Launch a multi-year, multi-media social marketing campaign to promote HIV testing and care:** An adequately funded and well targeted social marketing campaign, informed by and

focused on populations most affected by HIV, is needed to promote the benefits of HIV testing, care and treatment. Leveraging corporate and philanthropic support, the multi-media initiative should aim to increase HIV awareness, decrease stigmatizing beliefs about PLWHA, and promote HIV testing and care acceptance. The effort should be sustained, evaluated, and improved over a 10-year period.

- c) **Expand HIV testing and mandate linkage to care:** Assisting people with undiagnosed HIV infection to learn their HIV status and gain access care, and supporting people in initiating and maintaining care, are critical to ending the epidemic. Recommendations include: (i) Expand access to and utilization of voluntary HIV testing by adequately reimbursing for HIV testing services in all appropriate settings, mandating the offer of testing in clinical settings as a standard of care, integrating HIV testing services with sexually transmitted infection (STI), viral hepatitis, reproductive health, and tuberculosis services, and promoting testing acceptance through the campaign noted above. (ii) Utilize targeted testing models that incorporate social and structural risk factors in addition to behavioral risk to identify the most at-risk individuals. Redefine the role of testing providers in all settings to include specific steps to link people diagnosed with HIV to care, treatment, prevention and social services. (iii) Create pilot initiatives in 35 high-incidence settings to develop models of HIV testing outreach, care linkage, case finding and retention-in-care programs, and bring the most promising approaches to scale in multiple settings. Identify and implement best practices, such as peer-based outreach, linkage, and retention programs to engage people in care in these 35 settings.¹ (iv) Double funding over five years for STI and hepatitis services and conduct research to foster community-level screening and treatment initiatives.
- d) **Make critical health care system reforms:** Health reform legislation will be a game changer in the domestic HIV epidemic and it must be a top Administration priority. Whether as part of comprehensive health reform or stand-alone legislation, the Strategy must pursue (i) Medicaid expansion for all low-income individuals, including childless adults, to dramatically expand voluntary HIV testing and support access to standard of care for uninsured HIV-positive people, (ii) Medicaid reform to correct unequal Medicaid financing across the country, establish a standard benefits package and raise reimbursements to no less than Medicare rates, (iii) an adequately funded Ryan White program that wraps around health reform and provides uninterrupted, portable access to the AIDS Drug Assistance Program, and (iv) adequate federal investments in health and wellness activities, including infectious disease prevention and core public health activities.
- e) **Scale up strategic programming for African American men and women, gay men and other MSM, and others most affected:** The shape of the domestic epidemic demands a government response capable of making sometimes politically difficult choices about targeting resources and programming consistent with the population and geographic profile of the epidemic and coordinating multiple health and social services appropriate for communities facing a variety of challenges.² This means developing scaled, strategic programming for African American women and men regardless of sexual orientation, and gay men and other

¹ Initiatives in Washington, DC (to promote testing and linkage to care), and San Francisco (to use multiple data sources to identify geographic areas with under-utilization of care and treatment), among others, should serve as national models for these initiatives.

² As a recent article notes (El-Sadr, W, et al, AIDS in America, NEJM, Feb 10, 2010), the domestic epidemic is characterized by “low prevalence in the general population, high prevalence among the disenfranchised and socially marginalized, with a concentration in geographic hotspots.”

MSM, regardless of race or ethnicity, among other populations. Work across federal agencies to ensure there is appropriate guidance on regularity of HIV testing, care and treatment for groups at elevated risk, including gay men/MSM, African American men and women, and Latino/as. For example, establish a twice yearly HIV/STI screening quality-of-care standard for African American men; establish standards for explicit integration of sexual and reproductive health services with HIV services; promote capacity development for care providers serving African Americans, Latinos and others; establish a high-quality prevention and care services network with emphasis on reaching African Americans and Latino/as.

- f) **Create Health Renewal Zones in 25 communities with high incidence and suboptimal care utilization:** Recognize and act on the social and structural factors that drive vulnerability to infection by providing—in no less than 25 communities—an array of behavioral, social, housing and structural interventions to address those factors that create vulnerability to HIV, STIs and other health conditions. Ultimate success in responding to domestic HIV/AIDS will require the political courage to concentrate testing, care, treatment and other services where incidence and prevalence are most acute. The creation of Health Renewal Zones must include careful evaluation of the impact of these zones over a five-year period. Include as outcome measures a variety of health and wellness markers, not only HIV and STI incidence, for both the individual participants and the community.
- g) **End the epidemic among injection drug users:** Take advantage of the new availability of federal funds for syringe exchange programs by launching a comprehensive campaign to end or greatly reduce HIV incidence among injection drug users, their partners, and family members. A campaign utilizing syringe access programs, substitution therapy (e.g. methadone), substance abuse treatment, and other program and policy approaches should be launched to accomplish this goal within five years.
- h) **Improve sexual health programming and make HIV prevention more accountable.** Create and fund model comprehensive sexual health programs nationwide that are appropriate for adolescents and adults at elevated risk for HIV acquisition and transmission, including young MSM. Expand funding for age-appropriate, comprehensive sexuality education that includes affirming education about LGBT people. Renew efforts to design and deploy prevention interventions geared toward HIV-positive individuals and aimed at addressing prevention among sexual networks. Place new emphasis on accountability by regularly assessing HIV prevention strategies at CDC and the state and community level. The Diffusion of Evidence-Based Interventions (DEBI) program has valuable elements, but the premium in this and other programs must be placed on implementing scalable programs that can be locally delivered to measurably reduce incidence.
- i) **Expand and coordinate essential housing, substance abuse, mental health services:** Housing must be a critical component of any comprehensive approach to HIV/AIDS in the United States. Substance abuse and mental health services are chronically underfunded and should be deployed strategically with other HIV-related services, requiring close collaboration between SAMHSA, CDC, HRSA, HUD, VA and other agencies.
- j) **Ensure HIV research advances the Strategy's three goals:** The three central goals of the Strategy should be the guideposts for federal domestic HIV/AIDS-related research planning. The federal government must place a new premium on research that can be quickly and readily applied in the field and evaluated for both individual benefit and population-level impact. There is inadequate attention to the development and testing of interventions for African-American men and women; Latinos and Latinas; gay men and other MSM of all ethnicities; bisexuals; and transgender populations; and victims of violence and trauma. Expanded

research on social determinants of health and structural prevention and care interventions is needed as are effective HIV interventions that target social determinants. A cross-agency strategic HIV/AIDS research plan is needed to ensure collaboration and coordination among the government's major research agencies.

4. Prepare for implementation: The White House must identify immediate action steps, responsible entities, and deadlines to begin realignment of HIV-related activities around the targets and priority activities of the Strategy. Without deliberate attention to implementation, the Strategy risks being ignored.

While changing the approach, goals, targets, activities, and coordination of federal HIV-related activities will take time, and in some cases legislative authority, the White House must seize the opportunity presented by the Strategy to establish specific and immediate implementation steps that will occur this year and in 2011. We suggest the following:

EXAMPLES

- a) Establish in FY11 appropriations legislation requirements for all federal agencies involved in domestic HIV-related activities to report to ONAP by January 2011 on the ways their activities and budgets match the goals, targets, and activities of the Strategy as well as the specific collaborative activities begun to maximize scarce federal HIV resources. Reports will be made publicly available on the ONAP website.
- b) ONAP will work with PACHA, its Interagency Task Force, and the Tri Caucus to draft legislation no later than World AIDS Day on December 1, 2010 to create a PEPFAR-like domestic program, as described in the Strategy.
- c) CDC will report to ONAP and PACHA by World AIDS Day on the ways the Division of HIV/AIDS Prevention's Strategy Plan advances the Strategy. A calendar will be established by January 2011 for other agencies to similarly report on their plans to support implementation of the Strategy.
- d) ONAP will develop the first annual HIV/AIDS in the U.S. report card on progress toward Strategy targets to coincide with the President's State of Union address in 2011.
- e) PACHA will provide ongoing assessment of what federal agencies have done to improve coordination and reform policy and programming to accomplish Strategy goals and targets.
- f) Multiple stakeholders (including community representatives and PLWHA), and other sectors (including business, philanthropy and the faith based community) should be engaged in an ongoing fashion in reviewing Strategy priorities and monitoring implementation.

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APPENDIX A

The Strategy must provide detailed targets with transparent derivations that analyze likely outcomes under a bold, adequately funded plan as compared to no action. Federal officials will need to employ rigorous science in calculating models for the Strategy. The following is an example.

Indicators for a National HIV/AIDS Dashboard	By the End of 2015, Projections Assuming Flat Transmission Rate		By the End of 2015, Projections Assuming Targets Are Achieved	
Prevalence: The number of people living with HIV/AIDS during a given year.	1.5 million	i	1.37 million	ii
Incidence: Annual number of people who become HIV infected.	77,000	iii	32,000	iv
Transmission Rate: Represents the amount of transmission that occurs annually in relation to the population infected with HIV (technically, this is HIV incidence divided by prevalence in a given year).	5%	v	2.35%	vi
Serostatus Awareness: The percentage of HIV-positive people aware of their diagnoses.	80%	vii	85%	viii
Standard of Care: A uniform service standard that includes medical, housing, and other indicators of state-of-the-art HIV medical and non-medical treatment. It will be developed, implemented, and monitored to measure population-level access in obtaining the defined standard of care.	<50%	ix	85%	x
Optimal Health: A uniform standard that includes HIV-related indicators (such as CD4, viral load, and opportunistic infections) as well as other health indicators and quality of life measures.	<50%	xi	85%	xii
Late Diagnosis: The percentage of people who obtain an AIDS diagnosis within 12-months of receiving an HIV diagnosis.	35%	xiii	20%	xiv
Deaths: The number of people with HIV/AIDS who die in a given year from all causes.	26,000	xv	24,000	xvi
Incidence Among MSM and POC: Projected annual transmissions among men who have sex with men (MSM) of all races/ethnicities and among people of color (POC) for all genders and modes of transmission.	40,000 (MSM) 50,000 (POC)	xvii	17,000 (MSM) 20,000 (POC)	xviii

APPENDIX B

The Strategy must provide detailed annual projections—derived from rigorous science—for the likely course of the epidemic if a bold and adequately funded Strategy is implemented as compared to no action. The table that follows is an example; the projections developed for the Strategy should reflect more extensive analysis and peer review. (The incidence estimate in the scenario on the left assumes a stable transmission rate of approximately 5% based on 2006 data published in 2008 by Hall HI et al. (Hall HI, Song R, Rhodes P, et al. Estimation of HIV incidence in the United States. JAMA 2008;300(5):520-529)

Year	Projected Epidemic, ^{xi} No Reduction in Transmission Rate			National HIV/AIDS Strategy, Targets Achieved ^{xix}		
	Incidence ^{xxi}	Deaths ^{xxii}	Prevalence	Incidence ^{xxiii}	Deaths ^{xxiv}	Prevalence
2006			1,106,400 ^{xxv}			
2007	58,086	19,000	1,145,486			
2008	60,138	19,473	1,186,151			
2009	62,273	20,876	1,227,548			
2010	64,446	21,605	1,270,389			
2011	66,695	22,359	1,314,726	56,100	22,359	1,304,131
2012	69,023	23,139	1,360,610	48,835	22,953	1,330,014
2013	71,432	23,947	1,408,095	42,511	23,408	1,349,117
2014	73,505	24,782	1,457,238	37,006	23,744	1,362,379
2015	76,505	25,647	1,508,095	32,214	23,978	1,370,614
2016	79,175	26,542	1,560,728	31,000	24,123	1,377,492

i Based on current levels of HIV incidence and death remaining stable over five years. See detailed table on Appendix B.

ii Based on a 50% incidence reduction by 2016. See detailed table on Appendix B.

iii Based on a constant transmission rate of 5% for the period 2007-2015 based on baseline analysis from Hall HI, Song R, Rhodes P, et al. Estimation of HIV incidence in the United States. JAMA 2008;300(5):520-529.

iv Based on a 12.5% annual incidence reduction from 2011 to 2016. See detailed table on Appendix B.

v Based on projected HIV incidence divided by projected HIV prevalence. See detailed table on Appendix B.

vi Ibid.

vii Assumes virtually stable rates of undiagnosed HIV infection at 20% of all HIV-positive people. By the end of 2015—assuming no progress on the NHAS—nearly 283,000 individuals would likely be unaware of their HIV infection.

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- viii Aims to increase the percentage of HIV-positive people aware of their HIV infection, from the current estimate of 79% to 85% in 2016. Based on projections in Appendix B, 199,060 would likely remain unaware of their HIV infection if progress were made on the NHAS. This represents an increase of nearly 84,000 HIV-positive people aware of their serostatus.
- ix Based on current estimated levels of medical treatment access (Fleming et al., "HIV Prevalence in the United States, 2000", Abstract #11, Oral Abstract Session 5, 9th Conference on Retroviruses and Opportunistic Infections, 2002.)
- x Aims to assure that 85% of people living with HIV meet the established standard of care by 2016.
- xi Based on low HIV care access as documented by Fleming et al. "HIV Prevalence in the United States, 2000," which estimated that 42% to 59% of people living with HIV/AIDS are not in regular HIV care.
- xii Aims to achieve optimal health, based on a yet-to-be-defined standard, for 85% of people living with HIV/AIDS.
- xiii Estimate assumes moderate reductions in late HIV testing from baseline published data: CDC. Late HIV Testing—34 States, 1996-2005. MMWR 2009; 58(24); 661-665.
- xiv Aims to achieve nearly a 50% reduction in late HIV testing by 2016.
- xv Based on stable death rates from all sources.
- xvi Aims to achieve a moderate 8% reduction in deaths despite aging of PLWHA population.
- xvii Calculation assumes population-level incidence at constant rates based on: CDC. HIV Prevention in the United States: At the crossroads. 2009. www.cdc.gov/hiv/resources/reports/pdf/hiv-prev_us.pdf (accessed Feb. 21, 2010).
- xviii By 2016, aim to reduce annual incidence among MSM and POC by 55-60% respectively, in comparison to projected incidence at current rates. Gains preventing HIV among African-American and Latino MSM should account for at least half of the incidence reductions in each group.
- xix The example targets described on page 2 are based on progress achieved over a five-year implementation period beginning 2011 through the end of 2015
- xx Achievement of the Strategy's targets will be dependent on adequate investments to bring needed activities to scale and aggressive implementation of management improvements.
- xxi Assumes a stable transmission rate of approximately 5% based on 2006 data published in 2008 by Hall HI et al. (Hall HI, Song R, Rhodes P, et al. Estimation of HIV incidence in the United States. JAMA 2008;300(5):520-529
- xxii A point estimate of 1.76% of prevalence has been used to calculate projected deaths that might result from all sources among persons with HIV/AIDS. The point estimate is derived from adjustments to case counts reported to CDC (HIV/AIDS Surveillance Report, 2007).
- xxiii To achieve a 50% reduction in incidence by 2016, annual HIV infections must decrease by 12% annually between 2011 and 2015.
- xxiv Based on a conservative mortality estimate for PLWHA of 1.76% resulting from all causes.
- xxv Hall HI, Song R, Rhodes P, et al. Estimation of HIV incidence in the United States. JAMA 2008;300(5):520-529.