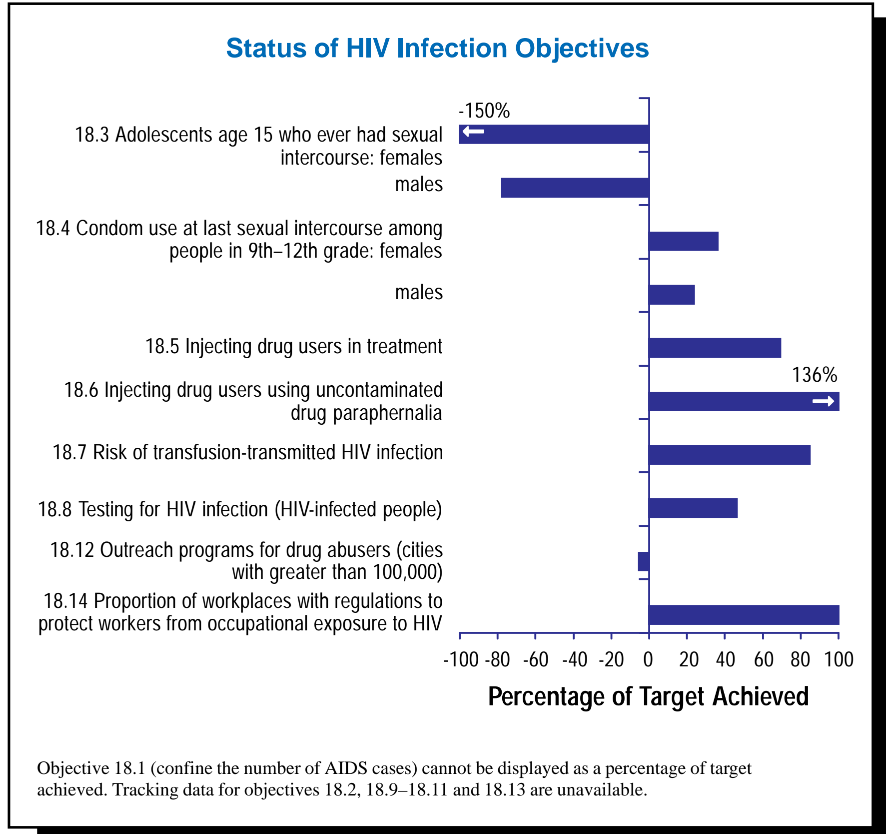
18 HIV Infection



Objective 18.1 (confine the number of AIDS cases) cannot be displayed as a percentage of target achieved. Tracking data for objectives 18.2, 18.9–18.11 and 18.13 are unavailable.

Lead Agency: ***Office of HIV/AIDS Policy***

HIV INFECTION

HIV/AIDS was unknown when the original 1990 objectives were developed in 1979–80. Ten years later, the HIV objectives for the year 2000 focused on HIV prevention, reduction of HIV incidence primarily through modification of high-risk behaviors, and health outcomes. Since the year 2000 objectives were written, the number of cases of AIDS has increased dramatically in the United States, affecting certain population groups differently. When *Healthy People 2000* was published, 114,500 AIDS cases had been reported. By the end of 1994, the number of AIDS cases (based on the expanded 1993 case definition) totaled 426,978. HIV infection was the 11th leading cause of death in the United States in 1989, and provisional data suggest that HIV/AIDS was the 8th leading cause of death in 1993. These same data also indicate that among blacks HIV infection was the 4th leading cause of death and that AIDS had become the leading cause of death for people aged 25–44.

As shown in the State map, 78,126 AIDS cases were reported to the Centers for Disease Control and Prevention (CDC) in 1994, for a rate of 30.0 per 100,000 population. The District of Columbia, New York, and New Jersey reported the highest rates of AIDS cases (although California reported the second highest number of cases), while North Dakota, Montana, and South Dakota reported the lowest rates of AIDS cases. (Note: The data on the map are by year of report, whereas objective 18.1 will be tracked by year of diagnosis.) Objective 18.1 seeks to confine the annual incidence of AIDS to no more than 43 per 100,000 population.

The lack of data presented a major problem in drafting the HIV objectives and continues to be a challenge today. While a national surveillance system was in place to track the number of AIDS cases, there were no good estimates—other than model-based ones—of the number of people infected with HIV; no scientifically justifiable projections 10 years into the future could be generated. Efforts were underway when the HEALTHY PEOPLE 2000 objectives were being drafted to conduct a feasibility study for the National Household Seroprevalence Survey; the study was not undertaken for methodological reasons and budgetary factors. All existing data were based on selected populations in certain localities. As of December 1994, 25 States required the reporting of HIV infection. These States have relatively low to moderate numbers of reported AIDS cases. Two other States require only pediatric HIV reporting.

The nature of the disease—with its relatively long incubation period between infection and symptoms—creates problems for tracking the progress of AIDS prevention efforts: most of the people who will be diagnosed as having AIDS between now and the year 2000 already have been infected. Tracking of AIDS case rates is complicated further by changes in the definition used for AIDS case reporting resulting from the ongoing evolution in the understanding of HIV disease and the care of HIV-infected people. With the last modification in the AIDS case definition in January 1993, the diagnosing and reporting of AIDS cases occurs earlier in the natural history of the disease. This change has resulted in a great but artificial increase in reported cases in 1993 that continued at a somewhat lower level in 1994. Surveillance data

on the number of AIDS cases are published both by year of report and by year of diagnosis; while the former are more readily available, the latter data more closely reflect the course of the epidemic. Trends in AIDS cases reflect technical and methodological factors, changes in survival rates, and differences in the course of the epidemic itself, thus making interpretation of HIV incidence trends difficult.

When the HIV objectives were developed, very little national data derived from the total population existed on the distribution of major sexual and drug-related risk behaviors. Two large, federally funded national studies of sexual behavior had been planned but were canceled because of concerns about the ability to collect such data. Without data on the number of people who inject drugs or the number of men who have sex with men, producing estimates in the form of rates for HIV infection, for AIDS cases, or for risk behaviors in these populations was not possible, even when reasonable numerator data were available.

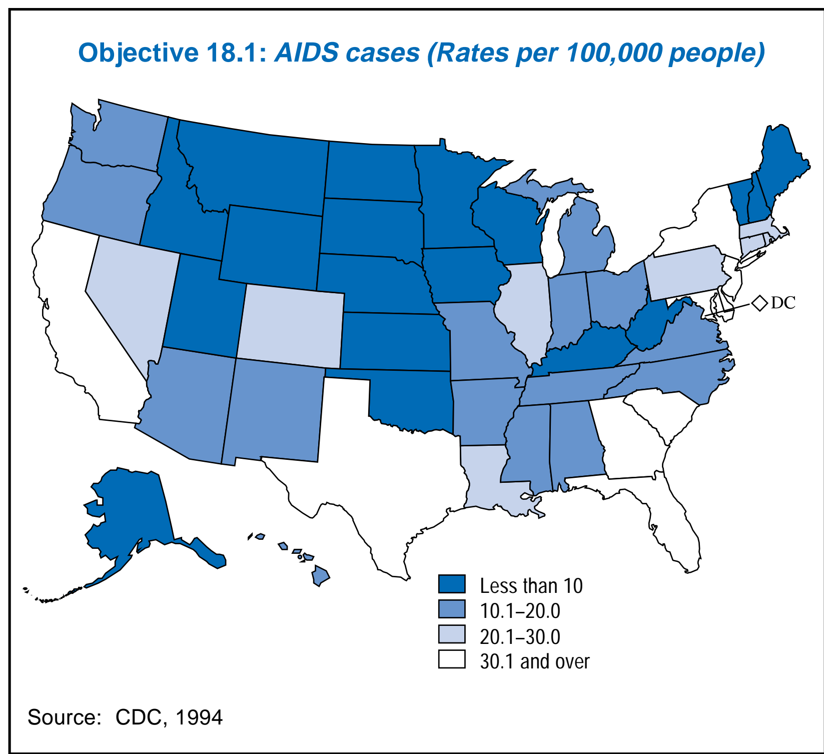
Review of Progress

This priority area monitors the numbers of people infected with HIV or with AIDS and some of the risk factors for becoming infected, including adolescents who engage in sexual intercourse, use of condoms, number of injecting drug users in treatment, and transfusion-transmitted AIDS cases. Among the services and protection objectives are education, counseling, testing, and partner notification as well as prevention of occupational exposures.

Assessing progress for objective 18.1 is difficult because of the impact of the recent changes in the AIDS case definition discussed above. New estimates of HIV infection in the total population are not yet available.

Five objectives show progress toward the targets. These include condom use; the percent of injecting drug users in treatment or who use uncontaminated drug paraphernalia; the increased percentage of HIV-infected people who have been tested; and the increased safety of the blood supply. Two objectives aimed at reducing risks of HIV infection are going away from the target: the

Objective 18.1: ***AIDS cases (Rates per 100,000 people)***



Source: CDC, 1994

number of adolescents engaging in sexual intercourse and the establishment of outreach programs for drug abusers. Baseline data for objective 18.9 show that clinicians do not routinely inquire about sexual practices of adolescents and adults. They do, however, provide counseling on HIV and sexually transmitted disease (STD) prevention more routinely. Nurse practitioners reported that they routinely inquired about sexual practices of 52 percent of their patients and routinely counseled 50 percent about HIV and STD infections. Tracking HIV education in colleges and universities requires baseline data. Regulations published by the Occupational Safety and Health Administration (OSHA) in 1991 protect workers from bloodborne infections including AIDS, thereby achieving the target for objective 18.14.

1995 Revisions

As the HIV epidemic has changed over time, new disparities have emerged in the rates of infection among subgroups of the population. The risks among these population groups have resulted in the addition of new special population targets. Women and injecting drug users are added to the special population targets tracked for AIDS cases.

Two new objectives have been added. One seeks to increase the number of worksites that implement a comprehensive HIV/AIDS workplace program in large and small businesses as well as in the Federal Government. A second new objective seeks to increase the linkages between primary care and substance abuse clinics. A shared objective 5.5 on adolescent abstinence from sexual intercourse has been added from the Family Planning priority area.

Other revisions include the tracking of objective 18.1 according to AIDS case rates per 100,000 population rather than the number of cases by year of diagnosis. While the revised measure will continue to reflect some of the tracking problems mentioned earlier, CDC now estimates the incidence of AIDS opportunistic illnesses (including HIV dementia and wasting syndrome) by year of diagnosis to make trend analysis more consistent. The target for objective 18.2 has been revised to confine the prevalence of HIV infection to no more than 400 cases per 100,000 people. At the time this objective was originally drafted it was believed that the epidemic was going to expand at a faster rate. The target for objective 18.6 was increased to strive for a higher percentage of injecting drug users who use only new or properly decontaminated drug paraphernalia. For objective 18.8, the measure will track the percentage of positive tests for which people return for counseling, as compared with those who have only been tested. Language in 18.10 seeks to clarify that the content of HIV and STD education curricula should be scientific and address prevention and disease transmission. For objective 18.11, the measure is shifted from the percentage of colleges that offer HIV education to the proportion of students who received HIV and STD education.