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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Office of the Assistant Secretary for Health
330 C Street, S.W., Room 2132
Washington, D.C. 20201

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TO: Kristine Gebbie

Telephone #: FAX #: 632-1096

# of PAGES (including this cover sheet): 2

FROM: **J. Michael McGinnis, M.D.**
Deputy Assistant Secretary for Health
(Disease Prevention and Health Promotion)
Telephone #: (202) 205-8611 **Fax #: (202) 205-9478**

MESSAGE:

If trouble with transmission, contact Delores Flenoury (202) 205-8583

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

Date JUN 27 1994

From Deputy Assistant Secretary for Health
(Disease Prevention and Health Promotion)

Subject Healthy People 2000 Progress Review on Nutrition

To PHS Agency Heads
Deputy Assistant Secretaries for Health
OASH Staff Office Directors
HHS Prevention Coordinating Group Members
Healthy People 2000 Priority Area Coordinators

The Healthy People 2000 Progress Review on Nutrition has been rescheduled **one hour earlier** and will now be held as follows:

Tuesday, July 5, 1994 at 1:00-2:30 p.m.

The meeting will be held in room 729G of the Hubert Humphrey Building.

J. Michael McGinnis, M.D.
Assistant Surgeon General

cc: Dr. Lee
Dr. Elders

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

RECEIVED
JUN 13 1994

Date JUN 7 1994

From Deputy Assistant Secretary for Health
(Disease Prevention and Health Promotion)

Subject Upcoming Healthy People 2000 Progress Review

Requests

To PHS Agency Heads
Deputy Assistant Secretaries for Health
OASH Staff Office Directors
HHS Prevention Coordinating Group Members
Healthy People 2000 Priority Area Coordinators

In addition to the Healthy People 2000 Progress Review currently scheduled for Tuesday, June 21, at 1:30-3:00 p.m. on Asians/Pacific Islanders, the next Progress Review has been scheduled as follows:

Tuesday, July 5, 1994, at 2:00-3:30 p.m. Nutrition

These meetings will be held in room 729G of the Hubert Humphrey Building.

J. Michael McGinnis, M.D.
Assistant Surgeon General

cc: Dr. Lee
Dr. Elders

No - I don't go to these on topics other than HIV

DEPARTMENT OF
HEALTH & HUMAN SERVICES

Office of the Assistant Secretary for Health
Washington DC 20201

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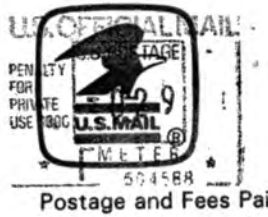

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HHS 396

Kristine Gebbie
National AIDS Policy Coordinator
Executive Office of the President
750 17th Street, NW, Suite 1060
Washington, DC 20500

HEALTHY PEOPLE 2000

HEALTHY PEOPLE 2000 is a national initiative to improve the health of all Americans through prevention. It is driven by 300 specific national health promotion and disease prevention objectives targeted for achievement by the year 2000. HEALTHY PEOPLE 2000's overall goals are to: increase the span of healthy life for Americans, reduce health disparities among Americans, and achieve access to preventive services for all Americans.

For more information about this unprecedented collaboration of both public and private sector groups, contact Lisa Kane, Office of Disease Prevention and Health Promotion, Room 2132, 330 C Street S.W., Washington, D.C. 20201; (202)205–9370.

Improving School Meals

The U.S. Department of Agriculture (USDA) has launched a "Nutritional Objectives for School Meals" initiative to improve the quality of school meal programs across the nation. Already the USDA has doubled the amount of fresh fruits and vegetables offered in cafeterias and increased the use of low-fat products in students' meals. In addition, the USDA held a series of four regional hearings and solicited written comments from the public on ways to improve school meals. Contact the Food and Nutrition Service, (703)305–2286.

Preventing Mental Health Disorders

Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research, from the Institute of Medicine's (IOM) Committee on Prevention of Mental Disorders, examines the results of a 24-month study on what is known about the prevention of mental disorders and the prospects for further advances in knowledge. The IOM, a component of the National Academy of Sciences, serves in an advisory capacity to the federal government and identifies issues of medical care, research and education. The committee urges three major developments for the mental health agenda: building the infrastructure to coordinate research and service programs and to train new investigators, expanding the knowledge base through research in other fields and performing well-evaluated preventive interventions. These goals reflect the objectives of HEALTHY PEOPLE 2000 to increase early interventions for adults and children at risk for mental health disorders. To order the 632-page report for $49.95, call (800)624–6242 or (202)334–3313. Contact Patricia Mrazek, study director, IOM, (202)334–2734.

UPDATE

Achieving the Nation's Health Objectives

NASA Employees Soar With "Total Health"

"Total Health," a NASA/Johnson Space Center (NASA/JSC) employee wellness program, offers a comprehensive package of health and wellness activities designed to assist employees in making healthier lifestyle choices. Menu changes, such as modification of portion sizes and method of preparation, reflect the current *Dietary Guidelines for Americans*. As a result, the center cafeteria now provides a low-cal, low-fat meal selection. Additional program components include a health screening physical, a wellness library and blood pressure screening. NASA's Office of Occupational Health hopes to make "Total Health" a model for other federal worksite programs. Contact Lynn Hogan, NASA/JSC Clinic, (713)483–7790.

total health

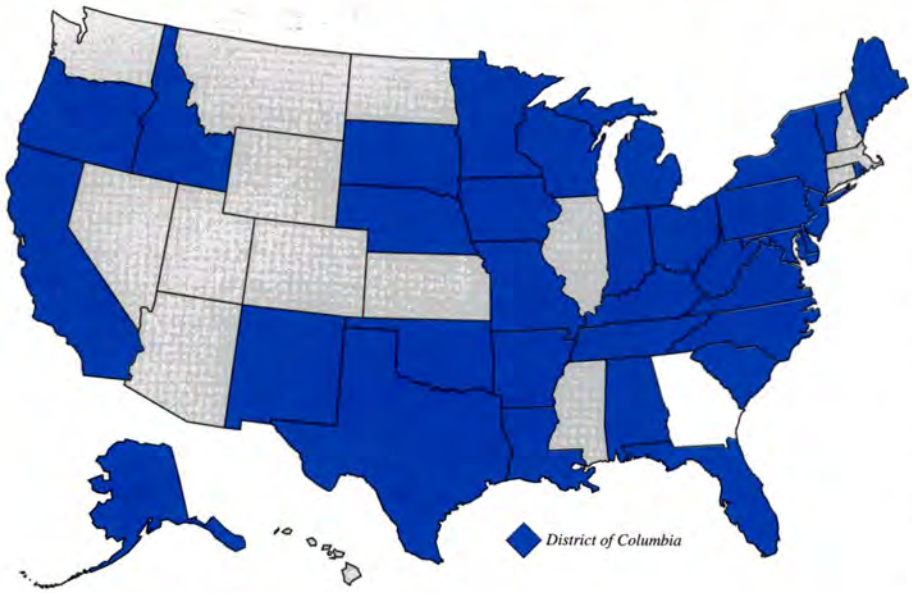
Initiative Targets Teen Pregnancy Prevention

"Teen Pregnancy Prevention 2000 Initiative (TPPI)," a health effort by The Colorado Trust Health Foundation, identifies and intervenes with people who are at an increased risk of teen pregnancy. Teen birth rates for 13- and 14-year-olds in Colorado doubled from 1980 to

(continued on back)

U.S. Department of Health and Human Services, Public Health Service Feb.-Mar. 1994

34 States and the District of Columbia Complete Year 2000 Plans



Objectives for the year 2000 have been completed by 34 states and the District of Columbia. Seven states—Alaska, Delaware, Maine, Maryland, Michigan, Ohio and Rhode Island—as well as the nation's capital finalized objectives during 1993 and thus far in 1994. Another 15 states have activities underway that may lead to year 2000 plans.

For many states, the development of year 2000 plans is the first phase of an action-oriented strategy to coordinate prevention interventions. The Office of Disease Prevention and Health Promotion (ODPHP) staff welcome your input on state activities. Contact Lisa Kane, (202)205–9370.

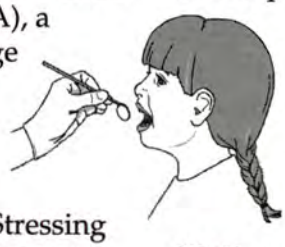
Teen Initiative

(continued from page 1)

1990. Six communities in the state will participate in the five-year initiative. Each community is currently setting priorities for action and reallocating existing local resources. TTPI has been designed to demonstrate that agency collaboration and case-managed community systems of care decrease teen pregnancy, increase healthy birth outcomes for young teens, improve parenting skills and decrease the possibility of unintended pregnancies. In addition, TTPI will provide preventive interventions to affect adolescent sexual and child-bearing decision-making in a positive manner. For more information on TTPI or The Colorado Trust's activities, contact Sally Beatty, The Trust, (303)837–1200.

Dental Program Fills Gap With Prevention Education

New York University's Dr. Samuel D. Harris Infant Dental Education Area (IDEA), a program of the College of Dentistry, focuses on oral health education for parents and caregivers of infants and young children. Stressing prevention rather than treatment, IDEA allows parents to view their child's mouth and observe the dental hygiene techniques being administered.



Interactive videotapes and play areas also emphasize self-help while providing a comfortable atmosphere for parents and their children. Contact Jill Fernandez, NYU Pediatric Dentistry Outreach Program, (212)998–9653.

Send Your News for the Update!

Healthy People 2000 Update is published for program planners to learn about prevention activities relating to achieving one or more of the nation's health promotion and disease prevention objectives. Program descriptions and contact information are provided to encourage sharing between organizations. Please send news about your HEALTHY PEOPLE 2000 programs and activities to the **National Health Information Center, P.O. Box 1133, Washington, D.C. 20013–1133**. Be sure to include sample program materials.

PROGRESS REPORT FOR: Environmental Health

ON NOVEMBER 10, 1993, the Public Health Service (PHS) conducted a review of progress on HEALTHY PEOPLE 2000 objectives on environmental health. Co-lead agencies for this priority area are the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH). An overview of strategies and barriers toward achievement of the year 2000 targets was presented by CDC's National Center for Environmental Health and NIH's National Institute for Environmental Health Sciences. They were joined for the review by invited guests from the Environmental Protection Agency (EPA); Department of Housing and Urban Development; Agency for Toxic Substances and Disease Registry (ATSDR); NIH's National Heart, Lung, and Blood Institute (NHLBI); Wisconsin Bureau of Public Health; American Lung Association; Howard University School of Medicine; and University of Oregon Health Sciences Center.

A brief overview of the 16 objectives in environmental health revealed that the available data show progress toward the year 2000 targets for 6 objectives. These data include an increased proportion of people living in counties meeting EPA air pollution standards (49.7 percent in 1988; 78.4 percent in 1992); an increased proportion of people who report their homes tested for radon (less than 5 percent in 1989; 7.4 percent in 1991); a reduction in toxic agents released into air, water, or soil (Department of Health and Human Services-listed carcinogens 0.48 billion pounds in 1988; 0.23 billion pounds in 1991; ATSDR-listed toxic chemicals 3.50 billion pounds in 1988; 2.16 billion pounds in 1991); more States requiring disclosure of lead-based paint or radon concentrations in property transfers (2 in 1989; 13 in 1993); more States with recycling programs (28 in 1987; 50 in 1991); and an increase in federally funded childhood lead poisoning surveillance programs (0 in 1990; 8 in 1993).

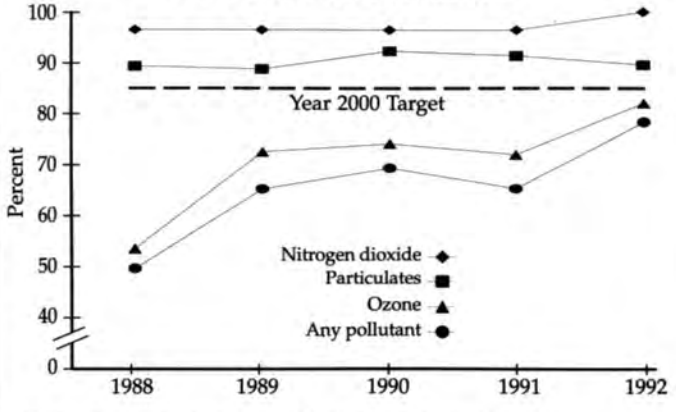
For three objectives, the data indicate trends that are moving away from their targets. Hospitalizations due to asthma increased from 188 per 100,000 people in 1988 to 196 per 100,000 in 1991. Also, an increased proportion of surface water has shown contamination, in part due to more focused assessments and stricter standards. Percent of surface water with potential risks to human health includes rivers (30 percent in 1988; 38 percent in 1992), lakes (27 percent in 1988; 44 percent in 1992), and estuaries (29 percent in 1988; 33 percent in 1992). Human exposure to solid waste contamination has increased from 4.0 pounds in 1988 to 4.3 pounds in 1990. Data for three objectives have remained essentially the same since the 1988 baseline measurement: the number of waterborne disease outbreaks, the number of community water systems that meet safe drinking water standards, and the number of States that have adopted construction standards to minimize elevated radon levels. New data are not yet available to track progress for the objectives that cover mental retardation, blood lead levels in children, testing of homes for lead-based paint, and the elimination of health risks from hazardous waste sites.

Focus on Asthma and Air Quality

The primary focus of this progress review was on the objectives covering air quality and asthma. EPA recently released the *1992 National Air Quality and Emissions Trends Report*, which shows generally positive trends across the range of criteria air pollutants. Air quality has improved considerably over the past several years (see chart below). In 1992, approximately 78 percent of people lived in counties that did not exceed the EPA standards for criteria air pollutants, an increase from the 1988 baseline of 49.7 percent. Although 1992 EPA data indicate some 54 million people living in counties with air pollutants exceeding EPA standards for air quality, more than 100 million people lived in such conditions in the mid-1980s. These improvements are largely attributable to such regulatory actions as the requirement for vehicle emissions testing and use of unleaded fuels.

While air quality data have shown improvement throughout the past decade, the participants noted that weather fluctuation can produce much measurement variation. EPA research continues on the health-related effects of short-term peak exposure to criteria air pollutants, for example, the influence of sulfur dioxide on people with asthma and the influence of ozone on individuals with lung disease.

Proportion of People Living in Counties That Have Not Exceeded Criteria Air Pollutant Standards

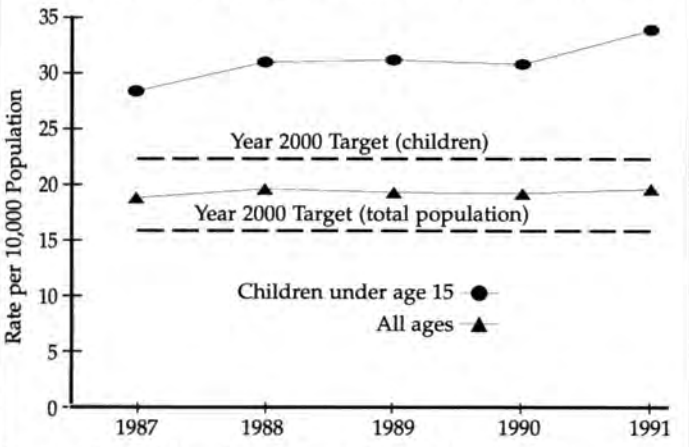


Note: Ambient air exposure during previous 12 months.
Source: *1992 National Air Quality and Emissions Trends Report*, EPA.

Asthma is a common ailment, affecting 9 to 12 million people in the United States; of these, approximately 3 million are children. A chronic disease with acute exacerbations, asthma requires ongoing medical management. The cost of illness related to asthma is estimated to be about $6.2 billion annually, with 4,000 to 5,000 deaths each year.

In many Western countries, including the United States, there has been an increased prevalence of both asthma morbidity and mortality during the past decade. As seen in the chart below, the 1987 baseline rate of asthma hospitalizations was 18.8 per 10,000 population. By 1991, this rate had increased to 19.6 per 10,000. Morbidity is even higher among young people. For children aged 14 and under, hospitalization rates increased from 28.4 per 10,000 in 1987 to 33.9 per 10,000 in 1991. The age-adjusted death rate for asthma was 0.12 per 10,000 population in 1986. In 1991, the rate had increased to 0.15 per 10,000. Mortality rates for blacks are more than twice as high as those for the total population, 0.30 and 0.35 per 10,000 for 1986 and 1991, respectively.

Trends in Hospitalization for Asthma



Source: National Hospital Discharge Survey, NCHS/CDC.

In the United States, asthma morbidity and mortality disproportionately affect children, women, minorities, and people in urban areas. One participant observed that asthma can be described as "a disease of civilization." Poverty is a common factor among those with asthma. The indoor environment also was cited as a significant factor. Possible contributing elements include inadequate humidity; appliances that have poor combustion systems; use of kerosene and gas heaters; exposure to allergens from dust mites, rodents, and roaches; and exposure to such irritants as tobacco smoke.

The etiology of asthma is not understood completely. Additional efforts are needed to identify risk factors more clearly and to develop improved intervention strategies. The interaction between genetic predisposition to asthma and environmental factors needs to be better understood. Areas for further research identified in the progress review include the potential role of occupational exposures and examination of a person's total exposure, including not only indoor irritants but also such outdoor pollutants as ozone and nitrogen dioxide. For elderly people, problems with asthma often may be associated with underlying factors related to smoking or chronic obstructive pulmonary disease.

Discussants also called for increased patient and provider education for better management of asthma, particularly in minority and urban communities, noting that NHLBI's National Asthma Education Program has published guidelines to improve the detection and treatment of asthma. The important role of the public health infrastructure at the community level was emphasized also. This role requires improved data collection and surveillance to track the disease and to determine the extent to which rising morbidity and mortality involve the transfer of diagnostic categories. Monitoring homes and mitigating the sources of irritants, and other efforts, such as increasing the number of nurses in public schools, would increase the public health capacity to detect and control asthma.

The progress review concluded with a summary of action items for achieving HEALTHY PEOPLE 2000 objectives, with a particular emphasis on asthma and air quality. These actions include re-evaluating the objectives in the context of the midcourse review; identifying key issues for a research agenda to characterize indoor air pollutants further as potential contributing factors toward asthma morbidity; determining the extent to which the science supports bringing asthma prevention and control efforts into communities; strengthening efforts to identify and manage individuals who have asthma, particularly young people; evaluating the potential role schools might play in improving surveillance, control, and management of asthma; and defining more clearly "preventable asthma events" as a public health indicator.

Public Health Service Agencies

Agency for Health Care Policy and Research
Agency for Toxic Substances and Disease Registry
Centers for Disease Control and Prevention
Food and Drug Administration
Health Resources and Services Administration
Indian Health Service
National Institutes of Health
Substance Abuse and Mental Health Services Administration
Office of the Surgeon General

HEALTHY PEOPLE 2000 Coordinator

Office of Disease Prevention and Health Promotion
330 C Street SW., Room 2132
Washington, DC 20201
202-205-8583
FAX: 202-205-9478

Philip R. Lee, M.D.
Assistant Secretary for Health

PROGRESS REPORT FOR: Hispanic Americans

ON SEPTEMBER 29, 1993, the Public Health Service (PHS) conducted a cross-cutting review of progress on HEALTHY PEOPLE 2000 objectives for Hispanic Americans. The Deputy Assistant Secretary for Minority Health and the PHS Minority Health Coordinators reviewed strategies and barriers toward achievement of the year 2000 targets. They were joined for the review by invited guests from the National Coalition of Hispanic Health and Human Services Organizations (COSSMHO), the ASPIRA Association, the University of Texas, and the University of California. The PHS participants included the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration, the National Institutes of Health (NIH), and the Substance Abuse and Mental Health Services Administration.

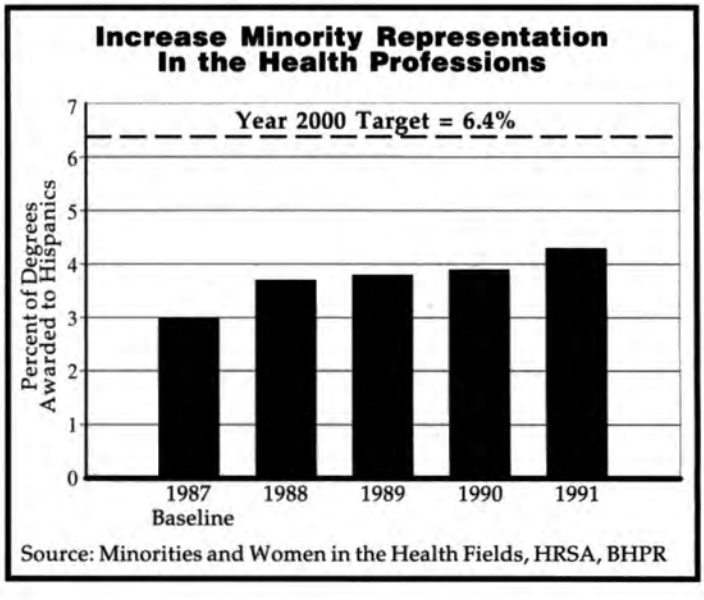
Although there are 30 objectives with targets for Hispanic Americans, several important health problems are not addressed. For example, no objectives exist to track the health of Hispanics in the areas of environmental health, sexually transmitted diseases, alcohol and other drugs, mental health and mental disorders, unintentional injuries, occupational safety and health, and food and drug safety. Efforts are needed to improve data collection and analysis in order to develop baseline measures more fully and to understand the nature of health trends among Hispanics. To the extent possible, the data also should take into account such factors as gender, acculturation, and ethnic subgroups.

A review of data for HEALTHY PEOPLE 2000 objectives which target Hispanics, as well as other data on Hispanic health, was presented by the CDC National Center for Health Statistics. For several objectives, the data indicate health status trends that are improving. The prevalence of cigarette smoking among Hispanic adults was 20 percent in 1991, well below the level of the total population. Infant mortality among Puerto Ricans has declined also. The participants noted that there is variation in infant mortality rates within Hispanic subgroups, and improvements are needed to better identify Hispanics in vital records. In addition, vital statistics data do not include people living in Puerto Rico.

The data also show that an increased proportion of Hispanic women are being screened for breast and cervical cancers. In 1990, 52 percent of Hispanic women aged 40 and over had received at least one mammogram, and 42 percent of Hispanic women aged 50 and over had received a mammogram within the preceding 2 years. These percentages compare with 1987 baseline measures of 20 percent and 18 percent, respectively. Although these health screening data indicate the number of women receiving this type of clinical preventive service has more than doubled, COSSMHO noted that Hispanics who speak only Spanish are much less likely to get screened.

The Hispanic population has a life expectancy approximately 3 years longer than the total population (79.1 for Hispanics and 75.4 for the total population in 1990). However, the years of healthy life for Hispanics are only 0.8 years more than the overall population (64.8 for Hispanics and 64.0 for total population in 1990). Years of healthy life take into consideration not only the life tables but indicators of morbidity as reported by activity limitations and self-reported health status from the National Health Interview Survey. Thus the quality of life for Hispanics, particularly in their later years, indicates some disproportionate dysfunction. In a discussion of these life expectancy findings, participants raised the possibility of underreported Hispanic deaths as one explanation. It was estimated, however, that this factor would account for only about a 10 percent difference in life expectancy.

Some progress is being made in the representation of Hispanics in health professions. The number of degrees awarded to Hispanics in these fields has increased from 3.0 percent in 1985-86 to 4.3 percent in 1991 (see graph below). Although improvement has been made, it was

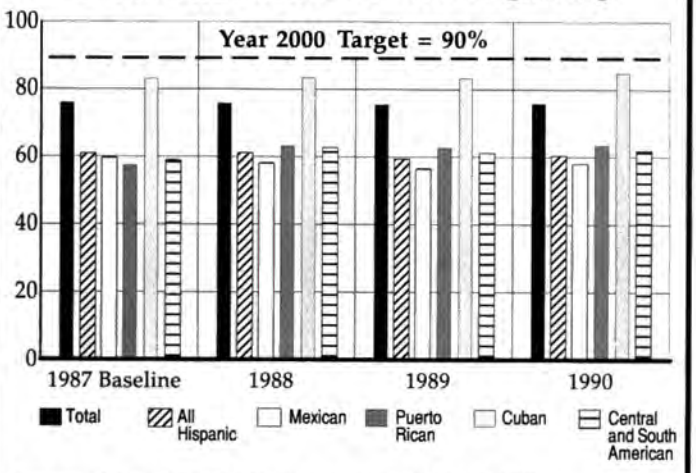


Source: Minorities and Women in the Health Fields, HRSA, BHPR

emphasized that to meet the year 2000 objectives in many of these areas, a more fully developed infrastructure needs to be in place, which includes increased numbers of Hispanic health professionals.

For several objectives, the data indicate health status trends that are not improving. Similar to the trends for all adult women, overweight prevalence has increased among Hispanic women. A recent article in the *New England Journal of Medicine* describes an increase in adolescent pregnancy among Hispanics in California. A related area of concern is that the proportion of pregnant Hispanic women who receive first trimester prenatal care has not increased. As shown in the graph below, the rate of first trimester care for Hispanic women (except Cubans) is generally about 20 percent lower than the rate for all women.

Increase the Proportion of All Pregnant Women Who Receive Prenatal Care In the First Trimester of Pregnancy



Source: National Vital Statistics System, CDC/NCHS

The homicide rate for Hispanic men aged 15 to 34 years has increased. In 1987, baseline data indicated a rate of 41.3 homicides per 100,000. By 1990, the homicide rate was 47.8 per 100,000. Although the incidence of tuberculosis has been increasing for many population subgroups, Hispanics accounted for 22.8 tuberculosis cases per 100,000 in 1991, more than double the rate of the total population. Newly diagnosed cases of AIDS have increased substantially. In 1989, baseline data indicated 8,000 AIDS cases diagnosed in Hispanics. By 1993, data reported through June showed 15,000 cases, almost double the baseline number.

Hispanics are not as likely to have access to primary health care as the overall population. In 1991, the National Health Interview Survey reported that 80 percent of the total population had access to primary care, compared with 64 percent of Hispanics.

The lack of progress regarding diabetes and its complications in the Hispanic community is another area of great concern. The 1982-84 baseline data show diabetes prevalence to be two times greater in Mexican Americans than in the total population, and no new data are available. Although the NIH National Institute of Diabetes and Digestive and Kidney Diseases has sponsored diabetes prevention control trials in minority communities within the last few years, the disease and the resulting complications continue to be substantial problems for this population. Participants pointed out the need for increased access to care, as well as preventive services that overcome cultural and language barriers.

Border health issues also were noted as an area of concern. In particular, the needs for improved access to health care by migrant workers and for an increase in initiatives addressing such diseases as diabetes and HIV/AIDS in underserved communities were discussed.

The progress review concluded with a summary of action items for achieving HEALTHY PEOPLE 2000 objectives. These include initiating an effort to review the objectives and to re-evaluate the targets relevant for Hispanics; identifying key areas and strategies for new data sources; developing a strategy to improve data on the prevention of diabetes in Hispanics; documenting and promoting successful methodologies that States and local communities can use for such key prevention areas as diabetes, violence, and obesity; and summarizing efforts that have been undertaken to increase the representation of Hispanics in the health care professions.

Public Health Service Agencies

Agency for Health Care Policy and Research
Agency for Toxic Substances and Disease Registry
Centers for Disease Control and Prevention
Food and Drug Administration
Health Resources and Services Administration
Indian Health Service
National Institutes of Health
Substance Abuse and Mental Health Services Administration
Office of the Surgeon General

HEALTHY PEOPLE 2000 Coordinator

Office of Disease Prevention and Health Promotion
330 C Street SW., Room 2132
Washington, DC 20201
202-205-8583
FAX: 202-205-9478

Philip R. Lee, M.D.
Assistant Secretary for Health

PROPOSED OUTSIDE ORGANIZATIONS FOR HP2000 PROGRESS REVIEW

HP2000 review draft materials

NATIONAL

Office of National Drug Control Policy
Linda Lewis?

National Commission on AIDS
Roy Widdus, Ph.D

AIDS Action Council
Jeff Levy

STATES

Association of State and Territorial Health Officials
Margaret Skelley
Project Director, HIV/AIDS

National Alliance of State & Territorial AIDS Directors
Julie Scofield, Executive Director

National Conference of State Legislatures
Tracy Hooker

(NCSL held a series of State Leader' Roundtables on HIV/AIDS Prevention throughout US this year to educate their membership on AIDS issues and involve them in a dialogue about solutions. Mimi Fields and Bob McAllister participated in the Western States Roundtable))

LOCAL GOVERNMENT

Conference of Mayors
Mara Patermaster (community oriented, Hispanic, ivdu issues)
B.J. Harris (Black, Direct line to Exec. Dir, rec. by CDC, CDC is working with the Conference on several programs)

National Association of County Health Officers
Nancy Rawding, Executive Director

ISSUE ORIENTED

Drug Abuse

National Association of State Alcohol and Drug Abuse Directors
William Butynski, Executive Director
Sandra Nelson, AIDS Policy

Don C. Des Jarlais, Ph.D
National Development and Research, Inc.
Needle Exchange and Treatment issues

Women's Issues

National Resource Center for and AIDS
Kathleen Stoll, Director
(Affiliated with the Center for Women Policy Studies, Kathleen also knowledgeable about HIV/AIDS and Adolescent girls)

Health Care Provider Education

Association of Anerican Medical Colleges
Robert F. Jones

American Red Cross
(just initiated a program in Pennsylvania to train 1500 health care workers)

American Medical Association
John Henning, Director, Division of HIV/AIDS

School Based Education

National Association of State Boards of Education

American College Health Association

NOTE: Not more than 5 outside people should be at the table.

August 12, 1993
Jo Messore
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HEALTHY PEOPLE 2000 PROGRESS REVIEW
WOMEN

August 2, 1993

Participants

Principals:

Philip R. Lee, M.D.
Assistant Secretary for Health

J. Michael McGinnis, M.D.
Deputy Assistant Secretary for Health
(Disease Prevention and Health Promotion)

Manning Feinleib, M.D., Dr.P.H.
Director, National Center for Health Statistics, CDC

Agnes H. Donahue, D.D.S, M.P.H.
Director, Office on Women's Health, OASH

D.A. Henderson, M.D.
Deputy Assistant Secretary for Health Science

Brian Biles, M.D.
Deputy Assistant Secretary for Public Health Policy

Claudia R. Baquet, M.D., M.P.H.
Deputy Assistant Secretary for Minority Health

PHS Coordinating Committee on Women's Health Issues:

Ruth L. Kirschstein, M.D.
Acting Director, NIH

Anne R. Bavier, M.N., FAAN
Women's Health Coordinator, AHCPR

Martha F. Katz
Director, Office of Program Planning and Evaluation, CDC

Ruth Merkatz, Ph.D., R.N.
Special Assistant to the Commissioner for Women's Health, FDA

Barbara Gaffney
Deputy Associate Administrator for Policy Coordination, HRSA

Luana L Reyes
Associate Director, Office of Planning, Evaluation and Legislation, IHS

Vivian Pinn, M.D.
Director, Office of Research on Women's Health, NIH

Mary Knipmeyer, Ph.D.
Acting Associate Administrator for Women's Services, SAMHSA

Invitees:

Leslie Wolfe, Ph.D.
Executive Director, Center for Women's Policy Studies
George Washington University

Susan Wood, Ph.D.
Science Advisor
Congressional Caucus for Women's Issues

Leah J. Dickstein, M.D.
President
American Medical Women's Association

Gwen Keita, Ph.D.
Associate Executive Director of Public Interest Directorate
Director of Women's Programs Office
American Psychological Association

Robyn Lipner
Staff Director
Subcommittee on Aging
Senate Committee on Labor and Human Resources

Alexine Jackson
Chairperson, National HIV/AIDS Task Force
Black Women's Agenda

Susan Galbraith
Co-Founder and Past Chair
Coalition on Alcohol and Drug Dependent Women and their Children

HEALTHY PEOPLE 2000

HIV Progress Review

Chairman: Dr. James O. Mason
Assistant Secretary for Health

I. Introductions and Overview of Objectives
(5 minutes)

J. Michael McGinnis, M.D.
Deputy Assistant Secretary for Health
Disease Prevention and Health Promotion

II. Key Elements in the PHS Strategy for HIV Objectives
(10 minutes)

James R. Allen, M.D., M.P.H.
Director, National AIDS Program Office

III. PHS Contributions to Implementing the Strategy
(10 minutes)

James R. Allen, M.D., M.P.H.
Director, National AIDS Program Office

IV. Key Non-PHS Contributions Necessary for Implementing the Strategy
(15 minutes)

John Farrell, M.S.W.
Chairman, AIDS Committee
National Association of State Alcohol and Drug Abuse Directors

Barbara DeBuono, M.D., M.P.H.
Member, HIV Committee
Association of State and Territorial Health Officials

Paula Van Ness, Executive Director
National Community AIDS Partnership

V. Recent Lessons Learned form Field Application of Strategy Elements
(15 minutes)

James R. Allen, M.D., M.P.H.
Director, National AIDS Program Office

VI. Discussion

Rev.-08/10/93

Priority Area 18
HIV Infection

Health Status Objective: AIDS

PHS Agency Assignment: National AIDS Program Office

18.1 Confine annual incidence of diagnosed AIDS cases to no more than 98,000 cases.

Annual incidence of Diagnosed AIDS Cases	1989 Baseline	1990	1991*	1992	2000 Target
Number of cases	49,000* (44,000-50,000)	55,000	68,000	87,000	98,000
Special Population Targets					
18.1a Men who have sex with men	27,000* (26,800-28,000)	30,000	35,000	42,000	48,000
18.1b Blacks	15,000* (14,000-15,000)	17,000	22,000	31,000	37,000
18.1c Hispanics	8,000 (7,000-8,000)	10,000	12,000	15,000	18,000

Note: Targets for this objective are equal to upper bound estimates of the incidence of diagnosed AIDS cases projected for 1993, based on AIDS case definition in effect in 1989.

*The original published baseline data were revised. The original numbers were based on preliminary analysis and are shown in parentheses.

Data Source: *AIDS Surveillance* System, CDC, NCID.

Rev.-08/02/93

Health Status Objective: HIV infection

PHS Agency Assignment: National AIDS Program Office

18.2	**Confine the prevalence of HIV infection to no more than 800 per 100,000 people.**

HIV Infection (per 100,000)	1989 Baseline	1990	2000 Target
Total population	400	400	800
Special Population Targets			
Estimated Prevalence of HIV Infection (per 100,000)			
18.2a Homosexual men	2,000-42,000[a]	12,500-57,500	20,000
18.2b Intravenous drug abusers	30,000-40,000[b]	0-51,500	40,000
18.2c Women giving birth to live born infants	150	150	100

[a]Per 100,000 homosexual men aged 15 through 24 based on men tested in selected sexually transmitted disease clinics in unlinked surveys; most studies find HIV prevalence of between 2,000 and 21,000 per 100,000.

[b]Per 100,000 intravenous drug abusers aged 15 through 24 in the New York city vicinity; in areas other than major metropolitan centers, infection rates in people entering selected drug treatment programs tested in unlinked surveys are often under 500 per 100,000.

Data Source: CDC, NCID.

Risk Reduction Objective: Adolescent postponent of sexual intercourse

PHS Agency Assignment: National AIDS Program Office

18.3 (5.4) (19.9)	**Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17.**

Adolescents who have engaged in sexual intercourse	1988 Baseline	1990	1991	2000 Target
Adolescents 15 years				
Females	27%	43%[a]	45%[a]	15%
Males	33%	53%[a]	51%[a]	15%
Adolescents 17 years				
Females	50%	67%[b]	65%[b]	40%
Males	66%	76%[b]	68%[b]	40%

[a]Among 10th grade students.
[b]Among 12th grade students.

Data Sources: Baseline - National Survey of Family Growth, CDC, NCHS; National Survey of Adolescent Males, NIH, NICHD; Updates - Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

Risk Reduction Objective: Condom use

Rev.-08/02/93

PHS Agency Assignment: National AIDS Program Office

18.4 (19.10)	**Increase to at least 50 percent the proportion of sexually active, unmarried people who used a condom at last sexual intercourse.**

Use of Condoms at last sexual intercourse	1988 Baseline	1990	1991	2000 Target
Sexually active, Unmarried Women Aged 15-44 (by their partners)	19%	---	---	50%
Special Population Targets				
18.4a Sexually active young women aged 15-19 (by their partners)	26%	40%*	38%*	60%
18.4b Sexually active young men aged 15-19	57%	49%*	54%*	75%
18.4c Intravenous drug abusers	---	---	---	60%

Note: Strategies to achieve the objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens who are not yet sexually active.

*Among 9th-12th grade students.

Data Sources: For 18.4 and 18.4a, National Survey of Family Growth, CDC, NCHS. Baseline - National Survy of Family Growth, CDC, NCHS, Updates (18.4a) - Youth Risk Behavior Survey, CDC, NCCDPHP; For 18.4b, Baseline - National Survey of Adolescent Males, NIH, NICHD, Updates - Youth Risk Behavior Survey, CDC, NCCDPHP.

Risk Reduction Objective: IV-drug abusers in treatment

PHS Agency Assignment: National AIDS Program Office

18.5	**Increase to at least 50 percent the estimated proportion of all intravenous drug abusers who are in drug abuse treatment programs.**

Enrolled in drug abuse treatment programs	1989 Baseline	1992	2000 Target
Intravenous drug abusers	11%	12.3%	50%

Data Source: Baseline: National Institute on Drug Abuse, NIH.

Risk Reduction Objective: IV-drug abusers using uncontaminated drug paraphernalia

PHS Agency Assignment: National AIDS Program Office

18.6	**Increase to at 50 percent the estimated proportion of intravenous drug abusers not in treatment who use only uncontaminated drug paraphernalia ("works").**

Use of uncontaminated drug paraphernalia	1991 Baseline	1992	200 Target
Intravenous drug abusers not in treatment	30.8%[a] (25-30%)	57%[b]	50%

[a]The original published baseline was revised. The original baseline was based on preliminary analysis and is shown in parentheses.
[b]Data are from January 1992 through April 1993.

Data Source: Baseline: National AIDS Demonstration Research Program, NIDA, NIH; Update: Cooperative Agreement for AIDS Community-based Outreach/Intervention Research Program, NIDA, NIH.

Risk Reduction Objective: Transfusion-transmitted HIV infection

PHS Agency Assignment: National AIDS Program Office

18.7	**Reduce to no more than 1 per 250,000 units of blood and blood components the risk of transfusion-transmitted HIV infection.**

Risk of transfusion transmitted HIV infection	1989 Baseline	1990	2000 Target
Units of blood	1 per 40,000-150,000	1 per 225,000	1 per 250,000

Data Sources: Baseline: Information from several studies provided by the American Association of Blood Banks; in San Francisco, risk is 1 per 82,000 units; FDA estimates 1/153,000; in Houston, 1 per 60,000. Update: Comprehensive Blood Donations Data Set, CDC, NCID.

Rev.-05/24/93

Services and Protection Objective: Testing for HIV Infection

PHS Agency Assignment: National AIDS Program Office

18.8	**Increase to at least 80 percent the proportion of HIV-infected people who have been tested for HIV infection.**

Testing for HIV infection	1989 Baseline	2000 Target
HIV-infected people	15%	80%

Data Source: HIV Counseling and Testing Data Sites System, CDC, NCPS.

Services and Protection Objective: Clinician counseling to prevent HIV and other sexually transmitted diseases

PHS Agency Assignment: National AIDS Program Office

18.9 (19.14)	**Increase to at least 75 percent the proportion of primary care and mental health care providers who provide age-appropriate counseling on the prevention of HIV and other sexually transmitted diseases.**

Counseling on HIV and STD Prevention	1987 Baseline	2000 Target
By primary care and mental health care providers	10%	75%
Special Population Target		
18.9a Providers practicing in high incidence areas	---	90%

Note: Primary care providers include physicians, nurses, nurse practitioners, and physician assistants. Areas of high AIDS and sexually transmitted disease incidence are cities and States with incidence rates of AIDS cases, HIV seroprevalence, gonorrhea, or syphilis that are at least 25 percent above the national average.

Data Sources: Baseline - Primary Care Physician Survey, of Sexual History-taking and Counseling Practices, Lewis, C.E., & Freeman, HE Western Journal of Medicine, 147, 165-167. 1987. Updates - Primary Care Providers Survey, OASH, ODPHP.

Services and Protection Objective: HIV education in schools

PHS Agency Assignment: National AIDS Program Office

18.10	**Increase to at least 95 percent the proportion of schools that have age-appropriate HIV education curricula for students in 4th through 12th grade, preferably as part of quality school health education.**

Age-appropriate HIV education curricula	1989 Baseline	2000 Target
Students in grades 4th through 12th	66%	95%

Note: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens who are not yet sexually active.

Data Source: *AIDS education: Public school programs require more student information and teacher training,* GAO, 1990.

Services and Protection Objective: HIV education in colleges and universities

PHS Agency Assignment: National AIDS Program Office

18.11	**Provide HIV education for students and staff in at least 90 percent of colleges and universities.**

HIV education for students and staff	Baseline	2000 Target
College and universities	Available in 1995	90%

Data Source: American College Health Association (Future).

Services and Protection Objective: Outreach to drug abusers

PHS Agency Assignment: National AIDS Program Office

18.12 **Increase to at least 90 percent the proportion of cities with populations over 100,000 that have outreach programs to contact drug abusers (particularly intravenous drug abusers) to deliver HIV risk reduction messages.**

Outreach to drug abusers about HIV risk reduction messages	1991 Baseline	2000 Target
Cities with populations over 100,000	35%	90%

Note: HIV risk reduction messages include messages about reducing or eliminating drug use, entering drug treatment, disinfection of injection equipment if still injecting drugs, and safer sex practices.

Data Source: CDC, NCPS.

Services and Protection Objective: Clinic services for HIV and other sexually transmitted diseases

PHS Agency Assignment: National AIDS Program Office

18.13 (5.11) (19.11)	**Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that screen, diagnose, treat, counsel, and provide (or refer for) partner notification services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia).**

Clinic services for HIV and other sexually transmitted diseases	1989 Baseline	2000 Target
Family planning clinics	40%	50%

Title X Funded Family Planning Clinics - 1990

Condition	Client Testing[a]	Client Treatment	Partner Notification[b]	Partner Testing	Partner Treatment
Syphilis	86%	48%	29%	57%	40%
Gonorrhea	97%	82%	23%	60%	62%
Chlamydia	66%	73%	15%	29%	50%

	Client Pretest Counseling	Client Testing
HIV	66%	60%

[a]Includes testing at initial visit, at annual visit, or if symptomatic.
[b]By family planning clinic staff via telephone or mail.

Data Sources: National Questionnaire on Provision of STD and HIV Services by Family Planning Clinics, PHS, OPA.

Services and Protection Objective: Occupational exposure to HIV

PHS Agency Assignment: National AIDS Program Office

18.14	**Extend to all facilities where workers are at risk for occupational transmission of HIV regulations to protect workers from exposure to bloodborne infections, including HIV infection.**

Protection from exposure to bloodborne infections, HIV	Baseline	2000 Target
Facilities with occupational exposure	---	100%

Note: The Occupational Safety and Health Administration (OSHA) is expected to issue regulations requiring worker protection from exposure to bloodborne infections, including HIV, during 1991. Implementation of the OSHA regulations would satisfy this objective.

Data Sources: OSHA regulations were published in the Federal Register on December 12.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

JAN 12 1994

Date

From Deputy Assistant Secretary for Health
(Disease Prevention and Health Promotion)

Subject Healthy People 2000 Progress Review for Cancer

To PHS Agency Heads
Deputy Assistant Secretaries for Health
OASH Staff Office Directors
HHS Prevention Coordinating Group Members
Healthy People 2000 Priority Area Coordinators

The Healthy People 2000 Progress Review on Cancer has been rescheduled for **January 26, 1994**. The meeting will be held in room 729G of the Hubert Humphrey Building at **10:30 a.m. to 12:00 p.m.**

J. Michael McGinnis, M.D.
Assistant Surgeon General

cc: Dr. Lee
Dr. Elders

THE WHITE HOUSE

WASHINGTON

NOV 18 1993

TO: National AIDS Policy Coordinator

FROM: HIV Policy Area Coordinators

SUBJECT: Revision Process, Healthy People 2000 Objectives

PURPOSE

As you know the Public Health Service (PHS) is beginning a midcourse review of the Healthy People 2000 National Health Promotion and Disease Prevention Objectives for the nation. The target for completion of this process is January 2, 1995. You have received a copy of the materials and have asked us, "How are we going to handle the HIV revisions?" The purpose of this communication is answer that question.

BACKGROUND

Revision of the HP 2000 objectives is under the general auspices of the PHS Office of Disease Prevention and Health Promotion (ODPHP). In general that office views this process as a "strategic correction." By that, ODPHP means that it does not want to become involved in a wholesale revision, but rather to correct for new science and new data. Also, it wishes to correct for inadequate wording in three areas, family planning, guns, and school health. The latter will impact on the HIV objectives, changing the wording in objective 10. Current wording is that HIV education in grades four through 12 would "preferably [be] part of quality school education." The change would read, "comprehensive [school or health] education." We (Jo and Bob) have recommended that this be a blanket change, made throughout the document by ODPHP and not by the individual work groups.

STATUS

On December 1, the PHS HP 200 steering committee will meet. One, or both of us will attend. The purpose of that meeting will be (1) to update the baseline data, (2) revise specific population data, and (3) review the candidates for revision (the three areas mentioned above). Items one and two are driven by data available to the National Center for Health Statistics (NCHS). We are also in the process of inquiring from our workgroup if there are data sources of which NCHS may be unaware.

OPTIONS

The are two levels of revision we might consider. The first is adding objectives for areas that are not now addressed. The second is the making substantive changes to existing objectives.

In general, we need to keep in mind the following: (1) HIV in this context is a part of a much larger project; (2) state planners have already incorporated existing HP 2000 objectives into their plans; (3) any changes or additions require justification in the literature, must be measurable, and must have a tracking source; (4) proposed changes and additions must be realistic, (5) the HIV work group which includes the PHS agencies, the Health Care Financing Administration, the Occupational Safety and Health Administration, and their constituents will be part of the process, and (6) proposed changes will be submitted to a public comment process.

Given the constraints and caveats presented above, are there health promotion, disease prevention areas not covered by the existing objectives? As a result of consultations with NCHS, CDC, and ODPHP personnel, we can say there is a consensus that the areas are covered. If you feel differently, we need to get it on the table.

The second question is, should these objectives be modified? Everyone agrees the objectives are not perfect and the data we have for tracking are not always a perfect fit. Nonetheless, again based on our consultations, we can say there is a consensus that writing changes will not lead to better objectives. It is hard, however, to generalize this. A few illustrative examples follow:

> We have an objective, number 11, to provide college students and staff with HIV education. Our data can only measure education provided to students. The feeling, however, is that the objective as written is a good reflection of our policy objectives and the data we can collect are indicative of our success.
>
> The worst of the objectives are probably the first two, AIDS cases and the prevalence of HIV infection. The consensus is that revisions to these objectives now will look just as inadvisable in a couple of years as do the current objectives. This is a moving target. The important point is that, as a nation, we feel these are important indicators and we should track them.
>
> It very difficult to estimate the number of drug users in the country as well as the number who are not in treatment. The drug objectives (5 and 6), however, capture our policy--

get users into treatment and have them use only uncontaminated equipment. The feeling is we should not get too hung up on not having good data. This is good policy.

RECOMMENDATION

We feel, as do the others we have spoken with, that we might be better off with a "context paper" that would become part of the HP 2000 document. The paper would discuss that the objectives are not perfect, but they are moving us (the nation) in the right direction, they are covering the important HIV health promotion, disease prevention considerations, and that we have measures and data that give us a reasonable indication that we are on track.

If you are uncomfortable with this recommendation, we would suggest that we meet to discuss it. The people with whom we would recommend you meet, are: Ron Wilson, from NCHS--he knows the history, the data, and rationale underpinning the HIV objectives; Mike McGinnis, Art Lawrence, and us. We would also suggest to Mike McGinnis that he consider including Phil Lee.

Johanne G. Messore
Research Specialist

Robert D. Moran
Planning Officer

CC: Dr. Lawrence

It'd be helpful to have a meeting - I talked with Ron Wilson about this on Thursday - I am not satisfied with a "context paper" - any objectives are moving targets - but we know just how far off some of those for HIV are - they could be re-assessed in 1996 if needed, but should it be left "as is" -

DEC 3 1993

Kristine:

You and I are scheduled to meet Monday (12/6) at 9 a.m. to discuss Healthy People 2000 Objectives. There are two items I would like to discuss:

1. The existing objectives and the changes that might be made. I have attached an objective by objective commentary with recommendations. This builds upon the memorandum Jo Messore and I sent to you on November 18. (There is another copy of that memorandum attached to this note if you need it.)

2. New objectives. If there are additional objectives you wish to add, I would like to discuss them and to discuss how they would relate or be incorporated into the Healthy People 2000 processes and documents.

For your information, I have also attached the latest guidance from the PHS Office of Disease Prevention and Health Promotion (McGinnis) regarding this process. If you and Mike McGinnis or Phil Lee have already come to some agreement on any of this, I very much need to know the playing field.

Lastly, also for your information, I have attached a work schedule to meet ODPHP's January 31 deadline. As I type this, it looks like the first date the workgroup can convene is January 12. I have stopped trying to query people until after our meeting.

Thanks for time and I am sorry to clutter your weekend with this stuff.

Bob

cc: Ms. Messore

Attachments:
Objective by objective review (1 pagers)
Messore, Moran memorandum of November 18
Guidance from ODPHP re: HP2000 midcourse review
Work schedule

Midcourse Review, Healthy People 2000

Objective 18.01: Confine annual incidence of diagnosed AIDS cases to no more than 98,000 cases.

Subpart	a. Gay and bisexual men	No more than 48,000
	b. Blacks	No more than 37,000
	c. Hispanics	No more than 18,000

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
44,000-50,000	48,400	98,000	No change
Subparts			
26,000-28,000	27,800	48,000	No change
14,000-15,000	14,500	37,000	No change
7,000-8,000	8,200	18,000	No change

COMMENTARY

There is a political need to track cases.

Target could (perhaps should) be modified. We will need the assistance of CDC models. We suspect this to be a particularly controversial process, particularly arriving at special population numbers. CDC modelers will be very reluctant to project so far into the future, potentially rekindling commentary that politics drives the science.

RECOMMENDATIONS

Note in context paper, addendum, footnote, whatever, the following:

Little, if anything, can be done to prevent new cases. Almost all that will be reported through 2000 represent people who are already infected.

Recognition that any new target may look just as inadvisable in three years from as the 1990 targets look today.

Changes in case definition can change tracking data.

Change "gay and bisexual men" to "men who have sex with men."

COMPELLING ARGUMENT FOR CHANGE

Change in numbers is driven by new science. Projections through 1994 indicate that earlier projections were in error on the "up side."

Change in wording is driven by our need to address all males who have sex with other males whether or not they identify with the label gay or bisexual.

Midcourse Review, Healthy People 2000

Objective 18.02: Confine the prevalence of HIV infection to no more than 800 per 100,000 people.

Subpart a.	Homosexual men	No more than 20,000
b.	Intravenous drug users	No more than 40,000
c.	Women giving birth to live-born infants	No more than 100

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
400/100,000	No Change	800/100,000	Not Applicable
Subparts			
2,000-42,000	15,000-61,000	20,000	Unclear
30,000-40,000	No Change	40,000	Not Applicable
150	No Change	100	Not Applicable

COMMENTARY

Objective is "politically correct," even though we do not have a representative national data to track it.

The target could be modified, downward, given what we now know.

RECOMMENDATION

Note in the context paper, addendum, footnote, whatever:
Numbers will not only changes in response to new infections, but in response to changes in treatment and longevity, neither of which are currently predictable.

Change "homosexual" to "men who have sex with men."

COMPELLING ARGUMENT FOR CHANGE

Change in target is driven by new science.

Change in wording is driven by our need to address all males who have sex with other males whether or not they identify with the label gay or bisexual.

Midcourse Review, Healthy People 2000

Objective 18.03: Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17.

Changes in Data

How This Objective Is Measured	Baseline			Result Of Proportional Adjustment
	Original	Revised	Target	
Girls by age 15	27 percent	No Change	15 percent	Not Applicable
Boys by age 15	33 percent	No Change	15 percent	Not Applicable
Girls by age 17	50 percent	No Change	40 percent	Not Applicable
Boys by age 17	66 percent	No Change	40 percent	Not Applicable

COMMENTARY

This objectives is repeated in HP 2000 chapters 5 and 19, which are family planning and sexually transmitted diseases, respectively. There will be a need to coordinate any change with those workgroups. Family planning has the lead.

RECOMMENDATION

Change baseline and tracking data to use the Youth Risk Behavior Surveillance System.

COMPELLING ARGUMENT FOR CHANGE

The original data sources were the National Survey of Family Growth and the National Survey of Adolescent males. The survey of family growth is no longer viable.

Midcourse Review, Healthy People 2000

Objective 18.04: Increase to at least 50 percent the proportion of sexually active, unmarried people who used a condom at last sexual intercourse.

Subpart a.	Sexually active young women aged 15-19 (by their partners)	Increase to at least 60%
b.	Sexually active young men aged 15-19	Increase to at least 75%
c.	Intravenous drug abusers	Increase to at least 60%

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
19 percent[1]	No change	50 percent	Not applicable
Subparts			
26 percent	No Change	60 percent	Not Applicable
57 percent	No Change	75 percent	Not Applicable
No data available	No Change	60 percent	Not Applicable

COMMENTARY

Data are a rough indicator of a more specific goal.

This objective is repeated in Healthy People 2000 chapter 19, sexually transmitted diseases. There will be a need to coordinate any change with that group. It has the lead.

The target of 50% recognizes that all sexually active unmarried people don't need to use a condom and that our ability to identify and track those at high risk (who do need to use a condom) may be difficult.

We need to supplement male data where possible.

RECOMMENDATION

Track objectives 18.4a and 18.4b with Youth Risk Behavior Surveillance System data by grade.

COMPELLING ARGUMENT FOR CHANGE

This is a more reliable data source.

1. Nineteen percent of sexually active, unmarried women, aged 15 to 44, reported that their partners used a condom at last sexual intercourse in 1988.

Midcourse Review, Healthy People 2000

Objective 18.05: Increase to at least 50 percent the estimated proportion of all intravenous drug abusers who are in drug abuse treatment programs.

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
11 percent	No Change	50 percent	Not Applicable

COMMENTARY

The SAMHSA National Household Survey on Drug Abuse will provide tracking data.

For tracking purposes, we need to define injecting drug user as anyone who has used a needle in the past year.

RECOMMENDATION

Note in context paper, etc., the definition "used a needle in the past year."

Change "intravenous drug abuser" to "injecting drug user."

COMPELLING ARGUMENT FOR CHANGE

On one hand, "injecting drug user" is the terminology of choice and it more accurately describes the transmission modality. On the other hand, it is not clear, for instance, that "drug abuse treatment" is appropriate for steroid users.

Objective 18.06: Increase to at least 50 percent the estimated proportion of intravenous drug abusers not in treatment who use only uncontaminated drug paraphernalia ("works").

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
25-35 percent	30.8 percent	50 percent	No Change

COMMENTARY

The SAMHSA National Household Survey on Drug Abuse will provide tracking data.

For tracking purposes we need to define injecting drug user as anyone who has used a needle in the past year.

RECOMMENDATION

Note in the context paper, etc., the definition "used a needle in the past year."

Change "intravenous drug abuser" to "injecting drug user."[1]

COMPELLING ARGUMENT FOR CHANGE

"Injecting drug user" is the terminology of choice and it more accurately describes the transmission modality.

1. The concern that was expressed in the commentary to objective 18.05 that the phrase "injecting drug use" may not be appropriate in that context is not apropos in the context of this objective.

Midcourse Review, Healthy People 2000

Objective 18.07: Reduce to no more than 1 per 250,000 units of blood and blood components the risk of transfusion-transmitted HIV infection.

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
1/40,000-150,000	No Change	1/250,000	Not Applicable

COMMENTARY

No comment.

RECOMMENDATION

Leave it as it is.

COMPELLING ARGUMENT FOR CHANGE

Not applicable.

Midcourse Review, Healthy People 2000

Objective 18.08: Increase to at least 80 percent the proportion of HIV-infected people who have been tested for HIV infection.

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
15 percent	No Change	80 percent	Not Applicable

COMMENTARY

The intent of this objective is reasonable, politically correct, and it is good policy. However, the measurement is very problematic. The data we have is from publicly funded clinics. Data with sufficient rigor to extrapolate from the data we have to the objective are unknown (to this writer).

RECOMMENDATION

In the absence of a better objective, make no change.

COMPELLING ARGUMENT FOR CHANGE

Not applicable.

Objective 18.09: Increase to at least 75 percent the proportion of primary care and mental health care providers who provide age-appropriate counseling on the prevention of HIV and other sexually transmitted diseases.

Subpart a. Providers practicing in high incidence areas — Increase to 90 percent

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
10 percent[1]	No Change	75 percent	Not Applicable
Subpart			
No Data	No Change	90 percent	Not Applicable

COMMENTARY

This objective is repeated in HP 2000 chapter 19, sexually transmitted diseases. There will be a need to coordinate any change with that workgroup. HIV has the lead.

RECOMMENDATION

Make no change.

COMPELLING ARGUMENT FOR CHANGE

Not applicable.

1. Number refers to physicians. Objective refers to "primary care providers" which is defined to include also nurses, nurse practitioners, and physician assistants.

Midcourse Review, Healthy People 2000

Objective 18.10: Increase to at least 95 percent the proportion of schools that have age-appropriate HIV education curricula for students in 4th through 12th grade, preferably as part of quality school health education.

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
66 percent	67 percent	95 percent	96.4 percent

COMMENTARY

All similar objectives in other priority areas will be changing from "quality" school health education to "comprehensive" school health education."

We track "school districts" not "schools" as stated in the objective.

RECOMMENDATION

We should support the change in wording and encourage ODPHP to do provide a blanket "compelling argument" for the change.

Accept that we will track "districts" not "schools."

The change is slight change in baseline is not worthy of response in the target.

COMPELLING ARGUMENT FOR CHANGE

We can develop "compelling argument" wording if it becomes necessary to do so independently.

Objective 18.11: Provide HIV education for students and staff in at least 90 percent of colleges and universities.

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
No Data	No Change	90 percent	Not Applicable

COMMENTARY

Data to track this objective will be available in 1995. It will address "students" not "students and staff" as specified in the objective.

RECOMMENDATION

Accept that we will track only "students."

COMPELLING ARGUMENT FOR CHANGE

Not applicable.

Midcourse Review, Healthy People 2000

Objective 18.12: Increase to at least 90 percent the proportion of cities with populations over 100,000 that have outreach programs to contact drug abusers (particularly intravenous drug abusers) to deliver HIV risk reduction messages.

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
No Data	No Change	90 percent	Not Applicable

COMMENTARY

The major criticism of this objective is that a single program in a city of a million people counts the same as a city of 100,000 people. However, we need to keep in mind that a number of programs a city needs depends on a host of factors (eg, scope of the epidemic, geographic and demographic distributions). These are issues for local programs.

RECOMMENDATION

Accept that, for tracking purposes, this is reasonable.

COMPELLING ARGUMENT FOR CHANGE

Not applicable.

Midcourse Review, Healthy People 2000

Objective 18.13: Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that screen, diagnose, treat, counsel, and provide (or refer for) partner notification services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia).

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
40 percent[1]	No Change	50 percent	Not Applicable

COMMENTARY

This is probably the most complex of the HIV objectives in terms of data. However, if we can track just one or two types of clinics, that should be a reasonable "indicator."

This objective is repeated in Healthy People 2000 chapter 19, sexually transmitted diseases. There will be a need to coordinate any change with that workgroup. It has the lead.

RECOMMENDATION

Make no change.

COMPELLING ARGUMENT FOR CHANGE

Not applicable.

1. The number refers only to family planning clinics for bacterial sexually transmitted diseases.

Objective 18.14: Extend to all facilities where workers are at risk for occupational transmission of HIV regulations to protect workers from exposure to bloodborne infections, including HIV infection.

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	

COMMENTARY

No need to modify this objective just because it has already been met. A number of the process objectives are of this nature.

RECOMMENDATION

Make no change.

COMPELLING ARGUMENT FOR CHANGE

Not applicable.

THE WHITE HOUSE

WASHINGTON

TO: National AIDS Policy Coordinator

FROM: HIV Policy Area Coordinators

SUBJECT: Revision Process, Healthy People 2000 Objectives

PURPOSE

As you know the Public Health Service (PHS) is beginning a midcourse review of the Healthy People 2000 National Health Promotion and Disease Prevention Objectives for the nation. The target for completion of this process is January 2, 1995. You have received a copy of the materials and have asked us, "How are we going to handle the HIV revisions?" The purpose of this communication is answer that question.

BACKGROUND

Revision of the HP 2000 objectives is under the general auspices of the PHS Office of Disease Prevention and Health Promotion (ODPHP). In general that office views this process as a "strategic correction." By that, ODPHP means that it does not want to become involved in a wholesale revision, but rather to correct for new science and new data. Also, it wishes to correct for inadequate wording in three areas, family planning, guns, and school health. The latter will impact on the HIV objectives, changing the wording in objective 10. Current wording is that HIV education in grades four through 12 would "preferably [be] part of <u>quality school education</u>." The change would read, "<u>comprehensive</u> [school or health] education." We (Jo and Bob) have recommended that this be a blanket change, made throughout the document by ODPHP and not by the individual work groups.

STATUS

On December 1, the PHS HP 200 steering committee will meet. One, or both of us will attend. The purpose of that meeting will be (1) to update the baseline data, (2) revise specific population data, and (3) review the candidates for revision (the three areas mentioned above). Items one and two are driven by data available to the National Center for Health Statistics (NCHS). We are also in the process of inquiring from our workgroup if there are data sources of which NCHS may be unaware.

OPTIONS

The are two levels of revision we might consider. The first is adding objectives for areas that are not now addressed. The second is the making substantive changes to existing objectives.

In general, we need to keep in mind the following: (1) HIV in this context is a part of a much larger project; (2) state planners have already incorporated existing HP 2000 objectives into their plans; (3) any changes or additions require justification in the literature, must be measurable, and must have a tracking source; (4) proposed changes and additions must be realistic, (5) the HIV work group which includes the PHS agencies, the Health Care Financing Administration, the Occupational Safety and Health Administration, and their constituents will be part of the process, and (6) proposed changes will be submitted to a public comment process.

Given the constraints and caveats presented above, are there health promotion, disease prevention areas not covered by the existing objectives? As a result of consultations with NCHS, CDC, and ODPHP personnel, we can say there is a consensus that the areas are covered. If you feel differently, we need to get it on the table.

The second question is, should these objectives be modified? Everyone agrees the objectives are not perfect and the data we have for tracking are not always a perfect fit. Nonetheless, again based on our consultations, we can say there is a consensus that writing changes will not lead to better objectives. It is hard, however, to generalize this. A few illustrative examples follow:

> We have an objective, number 11, to provide college students and staff with HIV education. Our data can only measure education provided to students. The feeling, however, is that the objective as written is a good reflection of our policy objectives and the data we can collect are indicative of our success.
>
> The worst of the objectives are probably the first two, AIDS cases and the prevalence of HIV infection. The consensus is that revisions to these objectives now will look just as inadvisable in a couple of years as do the current objectives. This is a moving target. The important point is that, as a nation, we feel these are important indicators and we should track them.
>
> It very difficult to estimate the number of drug users in the country as well as the number who are not in treatment. The drug objectives (5 and 6), however, capture our policy--

get users into treatment and have them use only uncontaminated equipment. The feeling is we should not get too hung up on not having good data. This is good policy.

RECOMMENDATION

We feel, as do the others we have spoken with, that we might be better off with a "context paper" that would become part of the HP 2000 document. The paper would discuss that the objectives are not perfect, but they are moving us (the nation) in the right direction, they are covering the important HIV health promotion, disease prevention considerations, and that we have measures and data that give us a reasonable indication that we are on track.

If you are uncomfortable with this recommendation, we would suggest that we meet to discuss it. The people with whom we would recommend you meet, are: Ron Wilson, from NCHS--he knows the history, the data, and rationale underpinning the HIV objectives; Mike McGinnis, Art Lawrence, and us. We would also suggest to Mike McGinnis that he consider including Phil Lee.

Johanne G. Messore
Research Specialist

Robert D. Moran
Planning Officer

CC: Dr. Lawrence

Guidelines for Healthy People 2000 Work Group Coordinators for the Midcourse Review Process

To respond to some of the most frequently asked question about the parameters of the midcourse review of Healthy People 2000.

What is the purpose of the midcourse review?

The midcourse review provides us with the opportunity to enhance the Nation's prevention agenda with new science, new information, and new data. It is the time to address potential problem areas for existing objectives and to refine them through language changes to the objectives or notes added to existing objectives. The midcourse review also provides us with the opportunity to fill any gaps.

Is the midcourse review the opportunity to drop objectives?

NO! All objectives will be maintained. However, to the extent that clarifying language could be substituted in an objective or added for improved tracking, or to provide additional subject focus, these issues will be considered.

Will year 2000 targets be changed?

No target will made easier to achieve. The revisions made to the targets to correspond with the baseline revisions will only be proportional to ensure that the challenge and improvement in health status we are seeking remains the same.

Will the special population targets be changed to correspond with the target for the objective?

All special population targets should narrow the disparity with the total population. The extent to which the target for a subobjective is identical to the target for the total population, it should be based on the criterion of realism. Is it realistic to expect that we will close the gap between a special population group and the total population by the year 2000?

We should use the latest data available for setting the baseline. The data that NCHS has available on specific population groups were shared in the November 2 memorandum. To the extent that you have additional national data sources which show a disparity or a different trend, please share this information with the NCHS Healthy People 2000 staff.

New special population targets should seek a percent change which corresponds with the change anticipated for other population subgroups taking into account the different time frame in the years remaining to the year 2000.

Through what process will new objectives, new subobjectives, revised objectives, or notes added to existing objectives be considered?

The lead agency/agencies for a priority area will be the conduit for all proposed revisions to a priority area, including all new special population targets. The lead agency/agencies should work with the Indian Health Service and the Office on Minority Health to identify new subobjectives.

The lead agency/agencies for a priority area may want to call on experts to review drafts of new objectives, new subobjectives and revised objectives similar to the process followed in 1988-89. Ideally this midcourse review should be a collaborative process.

What documentation will be needed to support new objectives, new subobjectives and revised objectives?

We will follow the same guidelines that were used in the year 2000 development process. The criteria for objectives appear on pages 92 and 93 of the full Healthy People 2000 report.

We will require that each proposed revision be accompanied by commentary which should include citations from the literature, data, data sources, and other materials to support the objective. The submission must also include the proposed language of the objective and subobjectives.

What time frames are the work groups operating under?

In order to have a first draft of the objectives ready for publication in the Federal Register in April 1994, the draft proposed objectives and supporting materials needs to be sent to the Deputy Assistant Secretary for Health (Disease Prevention and Health Promotion) by **January 31**.

The PHS Healthy People Steering Committee will meet on **February 15** to review these submissions.

Priority area lead agencies/work groups will be expected to incorporate PHS Steering Committee comments within the next two weeks.

A draft Federal Register notice, which summarizes the revisions, will be circulated by ODPHP on **March 15**.

Things to Do
HP 2000 Midcourse Review

Status	Due Date	Action Needed
✓	12/1	Attend HP 2000 steering committee
✓	12/1	Meet with J. Harrell and D. Maise
✓	12/1	Schedule meeting with K. Gebbie
✓	12/2	Inform J. Messore of meeting
✓	12/2	Brief G. Walter
✓	12/2	Brief A. Lawrence, invite to Gebbie meeting
?	12/6	Meet with Gebbie
✓	12/2	Review Messore/Moran memorandum to Gebbie
✓	12/3	Prepare one-page summary of midcourse guideline
✓	12/3	Prepare an objective by objective analysis with recommendation Send to her first
	12/6	Meeting
O	12/3	Schedule workgroup meeting week of Jan. 10
X	12/3	Ask Jo to call representatives
	12/10	Workgroup meeting package
O	12/9	Prepare objective by objective analysis with recommendation based on meeting with Gebbie
	12/3	Secure a meeting room
	12/9	Develop an agenda
	12/9	Develop formal memorandum
	12/10	Send out memo with analysis and agenda attached
		Should we ask for comments before the meeting?
	1/11	Meeting
	1/15	Develop product for ODPHP
	1/13	Do draft
	1/13	Offer Gebbie, Lawrence opportunity for review
	1/14	Send document to workgroup for comment
	1/31	Finalize document
	1/21	Wait for comments
	1/25	Revise product for ODPHP
	1/27	Clear document in NAPO/ONAP
	1/28	Revise document
	1/31	Send document to ODPHP

NATIONAL AIDS POLICY OFFICE
OFFICE OF THE COORDINATOR

ROUTING SLIP

DATE: 11/2

TO: KG

FROM: W. STEVE LEE

✓ For your information

____ For your action ____

____ Review and comment by (date) ____

____ Prepare reply for Coordinator's signature

____ Reply directly and blind copy Coordinator

____ **Circulate/**forward to: ____

____ File

COMMENTS: Copy sent to JS.

NOV - 1 1993

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

Date OCT 27 1993

From Deputy Assistant Secretary for Health
(Disease Prevention and Health Promotion)

Subject Healthy People 2000 Progress Review **Schedule Changes**

To PHS Agency Heads
Deputy Assistant Secretaries for Health
OASH Staff Office Directors
HHS Prevention Coordinating Group Members
Healthy People 2000 Priority Area Coordinators

The following schedule changes are in effect for upcoming Healthy People 2000 Progress Reviews:

The Progress Review on Cancer, which was scheduled for November 1, 1993 has been postponed, and is expected to be rescheduled for January, 1994, with the exact date still to be determined.

The Progress Review on Environmental Health, which was scheduled for November 10, 1993 from 1:30-3:00 p.m. has had a time change to 2:00-3:30 p.m. on that same day.

The Progress Review on Adolescents/Young Adults, which was scheduled for December 1, 1993 has been rescheduled to December 14, 1993 at 2:00-3:30 p.m.

The Progress Review on Nutrition, which was scheduled for December 22, 1993 has been postponed and will be held 1994, with a date still to be determined.

All of the Progress Reviews will be held in in room 729G of the Hubert Humphrey Building. We look forward to seeing you there.

J. Michael McGinnis, M.D.
Assistant Surgeon General

cc: Dr. Lee
Dr. Elders

NOTE TO THE HIV, HP2000 WORKGROUP

FROM: Co-chairs

SUBJECT: Healthy People 2000 Midcourse Review

Attachment one is an objective by objective review of the HIV, Healthy People 2000 (HP2000) National Health Promotion and Disease Prevention Objectives. Text in the objectives that looks like this: is new text that is proposed. Text in the objectives that looks like this: ~~is text that is proposed for deletion~~.

Following the statement of each objective is commentary regarding the rationale for each change proposed or the rationale for leaving an objective as it is. Some of the commentary is proposed for inclusion in the official HP2000 documentation . That text is clearly identified as a proposed addition because it looks like this.

The NCHS has analyzed the baseline data for each of the HP2000 objectives. In other priority areas this has meant a substantial change in the baseline. In the case of the HIV priority area, this is not so. All adjustments to the HIV data produce numbers that fall within the original estimates or produce changes so small as to be insignificant. Therefore, no changes are proposed for the HIV objectives based on modifications to the baselines.

Attachment two is a collection of tables that show the original baseline data, the revised baseline, and any proportional change that would show in the target as a result of the revision. It is proposed that the new baselines replace the old and that no change in targets result from this exercise. The ODPHP and NCHS will draft general text that explains the change to the baselines throughout the HP2000 document.

Johanne G. Messore Robert D. Moran

ATTACHMENT ONE

Objective by Objective Review

Objective 18.01: Confine annual incidence of diagnosed AIDS cases to no more than ~~98,000 cases~~ ____ per 100,000 population.

Subpart	a. ~~Gay and bisexual men~~ Men Who Have Sex With Men	No more than _____ ~~48,000~~
	b. Blacks	No more than ~~37,000~~ change to rate
	c. Hispanics	No more than ~~18,000~~ change to rate
	d. Women	No more than _____ per 100,000.

COMMENTARY

It is recommended that the objective be changed from tracking actual cases to tracking case rates. This change will facilitate comparisons of the national data with case data describing State and local areas. The following one-time note explaining the change is recommended: The original measure addressed by this objective was the number of AIDS cases by year of diagnosis. The revised objective now expresses the measure as a rate, the number of AIDS cases by year of diagnosis per 100,000 population. This allows more ready comparison of data at the national level with state and local data.

In February, CDC will convene a workgroup to reexamine its projections for HIV and AIDS. It is expected current projections will be revised then. Information generated from that workgroup will be used to revise this objective and to fill in the blanks.

When these objectives were formulated in 1989, it was thought that number of AIDS cases were increasing and, left unchecked, would continue to rise throughout the decade. It was thought then, that prevention programs would begin to impact on diagnosed cases during the decade, and, by the end of the decade, the nation would be able to reduce the number of cases diagnosed annually back to the level that was then projected for 1992. It is suggested, whether actual cases or case rates are used, the estimates for 1992 emerging from the workgroup that will meet in February be used as the basis to fill in the blanks. In this context, it should be noted that almost all the cases that will be diagnosed through 2000 will be among people who are infected as this is being written in 1994. [See below.]

Adding women as a subpart to this objective has been recommended from several quarters. Data to track this subpart exist. The target number will also be derived from the workgroup that is scheduled to convene in February.

The change in terminology from "gay and bisexual men" to "men who have sex with men" will be recommended universally throughout the HIV objectives. This is preferred terminology, better describes the target population, and does not unnecessarily exclude men who have sex with men but do not identify themselves to be homosexual or bisexual.

Using a rate for the category "men who have sex with men" is problematic. Estimates of this population range from 10 percent of all males to as little as one or two percent of all males. The choice of a denominator would have a major impact on the magnitude of the rate; i.e., the larger the denominator, the lower the rate.

Changes in case definition, such as occurred in 1993, can change tracking data. The following one-time note is suggested: AIDS cases reported to CDC through the AIDS Surveillance System are used to monitor this objective. The AIDS case definition has been revised periodically. This can affect both the target and monitoring of the objective. The latest revision was implemented in January 1993. That revision expanded the case definition to include HIV-infected people with severe immunosuppression as measured by CD4' T-lymphocyte

count of less than 200 cells per microliter or a CD4+ cell percentage of less than 14, whether or not those persons have opportunistic infections, neoplasms, or any other symptoms of HIV infection. The new case definition also adds pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer to the list of diseases that indicate AIDS has developed among HIV-infected people.

Because the new case definition for AIDS surveillance includes HIV-infected people with severe immunosuppression but without AIDS-defining clinical conditions, it allows counting people as AIDS cases earlier in the natural history of the infection. When the new case definition was first implemented, it was expected that it would increase cases reported in 1993 by approximately 75 percent (MMWR 1992:41 suppl, no RR17). During 1993, the number of cases reported increased __ percent over the previous year. It is expected that the short term effect on the number of cases reported will be greater than long term effects, because both prevalent as well as incident cases of immunosuppression will be reported. The new definition will also increase the number of cases by year of diagnosis for previous years.

Because this objective has the appearance of being straightforward and uncomplicated, it is proposed the following commentary appear in all future printing of the objectives. It is an attempt to explain some of the unique difficulties inherent with the objective: Measuring progress toward the attainment of this objective is confounded by several issues. The CDC AIDS case surveillance data are usually published by "year of report"; i.e., the year (date) that the case was reported to CDC. However, for the purposes of tracking this objective it was determined that the "year of diagnosis" was a better measure, since it more closely reflects the true course of the epidemic. The CDC estimates used to track this objective have been adjusted for both delays in reporting and for under reporting. While the adjusting models take into account differences between subgroups of the population, they do not always account for changes over time in under reporting and delays in reporting. Factors which effect under reporting may change over time with differing impact on the level of reporting delays and under reporting. Tracking AIDS cases by year of diagnosis also requires annual changes of the estimates for all previous years as late cases are reported to CDC. A major issue is that the definition for AIDS surveillance is modified periodically (the last modification was in January 1993). All definition changes in the past have had the effect of reporting AIDS cases earlier during the natural history of the disease, resulting in more cases being report in the period immediately following the change than would have been reported otherwise. In addition, under the immediately preceding definition the period from HIV infection to AIDS diagnosis was about eight to 10 years, thus, in terms of meeting this objective, most cases that will be diagnosed during the 1990s have already been infected. Therefore efforts to reduce the future number of AIDS cases will have little impact. However, with the 1993 change in the case definition, newly infected people will be diagnosed earlier, thus increasing the estimated number of AIDS cases in the future. Trends in AIDS cases, therefore, reflect changes in technical and methodological factors, as well as changes the epidemic itself, making the interpretation of these trends difficult.

Objective 18.02: Confine the prevalence of HIV infection to no more than ~~800~~ per 100,000 people.

Subpart a.	Men Who Have Sex With ~~Homosexual~~ Men	No more than ~~20,000~~
b.	Injecting ~~Intravenous~~ drug abusers ~~users~~	No more than ~~40,000~~
c.	Women giving birth to live-born infants	No more than ~~100~~

COMMENTARY

In February, CDC will convene a workgroup to reexamine its projections for HIV and AIDS. It is expected current projections will be revised then. Information generated from that workgroup will be used to revise this objective and to fill in the blanks.

The change in terminology from "homosexual men" to "men who have sex with men" will be recommended universally throughout the HIV objectives. This is preferred terminology, better describes the target population, and does not unnecessarily exclude men who have sex with men but do not identify themselves to be homosexual or bisexual.

It is proposed the following commentary appear in all future printing of the objectives. It is an attempt to explain some of the unique difficulties inherent with the objective: Measuring progress toward this objective is hindered by the lack of a nationally representative data base for estimating the rate of HIV infection. A 1989 study of the feasibility of conducting a National Household Seroprevalence Survey concluded that such a study should not be done due to a number of methodological and budgetary factors. Since that time, CDC has made national estimates of HIV infection based on statistical models using data from multiple sources (e.g., STD clinics, drug treatment centers, hospitals, Job Corps recruits, newborn infants) most of which are not representative of their respective target populations.

At the time the year 2000 target for this object was established there was not only uncertainty about the prevalence and incidence of HIV infection, but there was, and still is, considerable uncertainty about our ability to modify HIV risk behaviors and successfully treat people with AIDS. The future prevalence of any disease is determined by the current level of infection, the future rate of new infections, and the future death rate. While declining prevalence rates are preferable to increasing rates, major advances in the treatment of AIDS, which would reduce the death rate, would result in increases in the future prevalence rates. Hopefully, changes in risk behaviors will reduce the future rate of new infections, thus depressing the future prevalence levels.

Objective 18.03: Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17. (Baseline 27 percent of females ~~girls~~ and 33 of males ~~boys~~ by age 15; 50 percent of females ~~girls~~ and 66 percent of males ~~boys~~ by age 17; reported in 1988.)

COMMENTARY

This objectives is repeated in HP 2000 chapters 5 and 19, which are family planning and sexually transmitted diseases, respectively. There will be a need to coordinate any change with those workgroups. Family planning has the lead.

This change is proposed to correct counterproductive and insensitive text that inadvertently has made its way into this objective. Throughout the HP2000 document, people--regardless of age--who are having sex are referred to as adults, as males or females, or as adolescents when it is appropriate. Only when the subject is abstinence are target populations labeled "girls" and "boys."

This objective is based on optimistic expectations as what could be accomplished in this area. All data suggest that the rates of sexual initiation are increasing, and have been increasing for some time, at the age levels targeted. This trend is apparent over the last 20 years. Data would suggest the targets be reduced if the criterion of "realistic" were to be applied. A possibility, suggested with the Family Planning workgroup (HP2000 chapter 5) would be to develop age group subobjectives with large reduction at the youngest ages and lesser reductions at older ages. This approach would fail the criterion "no objective will be made easier to attain."

It is proposed that the tracking data, which were originally obtained from the National Survey of Family Growth and the National Survey of Adolescent Males be changed to the Youth Risk Behavior Surveillance System.

Objective 18.04: Increase to at least 50 percent the proportion of sexually active, unmarried people who used a condom at last sexual intercourse.

Subpart a.	Sexually active young women aged 15-19 (by their partners)	Increase to at least 60%
b.	Sexually active young men aged 15-19	Increase to at least 75%
c.	Injecting ~~Intravenous~~ drug abusers	Increase to at least 60%
d.	Men Who Have Sex With Men	Increase to at least __%

COMMENTARY

This objective is repeated in HP2000 chapter 19, sexually transmitted diseases. There will be a need to coordinate any change with that group. It has the lead.

It is proposed we add a "subpart d," men who have sex with men. Data for this objective can be obtained from the 1995 National Household Survey of Drug Abuse. It is anticipate that that survey will include questions about condom use at last sexual intercourse and about the sex of sexual partners during the last year.

It is proposed that the tracking data for subparts "a" and "b," which were originally obtained from the National Survey of Family Growth and the National Survey of Adolescent Males, be changed to the Youth Risk Behavior Surveillance System.

No changes in the target are proposed even though delays in implementing the prevention marketing campaigns has cast doubt upon our ability to achieve this objective by the end of the decade.

Midcourse Review, Healthy People 2000

Objective 18.05: Increase to at least 50 percent the estimated proportion of all injecting ~~intravenous~~ drug abusers who are in drug abuse treatment programs.

COMMENTARY

"injecting drug abuser" is the terminology of choice and it more accurately describes the transmission modality.

It is proposed the following commentary appear in all future printing of the objectives. It is an attempt to bring a degree of rigor to the achievement of this objective, but it may cause data collection problems for programs that track only contacts for treatment: The definition of "drug abuse treatment" employed must include more than contact for treatment and must recognized that treatment, to be effective, must be sustained. Therefore, contacts for treatment do not represent treatment.

For tracking purposes, should we define injecting drug abuser as anyone who has used a needle in the past year? Possible new text to appear in all future printings could be, "an injecting drug abuser is anyone who has used a needle in the past 12-month period."

There must be an agreed upon set of data bases. While the National Household Survey on Drug Abuse is the current measure, it may be possible before 2000 to refine the estimates based on State data bases that are now in development and should provide comparable data potentially capable of yielding valid national estimates. Also, the Client Data Survey may yield additional data of use in estimating treatment resources.

The National Survey on Drug Abuse measures varying levels of drug abuse from casual use through frequent use. It collects information on whether the person uses a needle to inject drugs and whether the person is in treatment. The National Drug and Alcoholism Treatment Unit Survey also collects information on the estimated percentage of those in treatment who inject drugs. Since the numbers of drug users that inject drugs is a very small percentage of the total population, if that is to be use as the definition of drug abuse, then it may be necessary to also utilize modeling efforts that are currently underway.

Achievement of this objective will be greatly affected by health care reform. It is expected that ODPHP will discuss this it the preference materials for all the HP2000 chapters. Therefore, it is proposed that it not be addressed in commentary appearing in the HIV chapter.

Midcourse Review, Healthy People 2000

Objective 18.06: Increase to at least ~~50~~ percent the estimated proportion of injecting ~~intravenous~~ drug abusers not in treatment who use only uncontaminated drug paraphernalia ("works").

COMMENTARY

Alternative revisions have been proposed:

1. Raise the target to 60 percent. It is apparent from current data that the HP2000 target is currently surpassed. However, since the initial objectives were developed, guidelines for the proper use of bleach have been reviewed and there is a body of evidence suggesting that bleach must be used in a more rigorous manner than was previously suggested if it is to be effective in reducing contamination. Data that do not specify the type of bleach decontamination may not accurately reflect the goal of having injecting drug abusers use only "uncontaminated" paraphernalia. Also, recent recommendations about the efficacy and desirability of increasing the support of needle exchange programs could have a measurable effect on the ability to reach a higher goal. At a minimum, it would seem reasonable to raise the target to 60 percent. There is a hesitancy to raise it above this point given uncertainties about the acceptance of needle exchange programs and the ability to increase more rigorous use of bleach.

2. Raise the target to a number derived from findings reported in the San Francisco study for needle exchange programs that have been ongoing for three, four, or five years. It now seems likely the Department will lift the ban on the use of Federal resources for needle exchange and that pharmacists and other legal distributors of needles and syringes will be encouraged to make them available. Local programs, especially programs in the epicenters of the epidemic, can be expected to implement new HIV prevention activities targeting drug abusers that will increase the prevalent use of uncontaminated equipment.

"Injecting drug abuser" is the terminology of choice and it more accurately describes the transmission modality.

For tracking purposes, should we define injecting drug abuser as anyone who has used a needle in the past year? Possible new text to appear in all future printings could be, "an injecting drug abuser is anyone who has used a needle in the past 12-month period."

The National Household Survey on Drug Abuse will provide tracking data. However, it does not currently collect information on whether uncontaminated drug paraphernalia are used. The survey only asks if the respondent is aware of anyone else using the needle before or after the respondent did. New modeling and sampling efforts are currently underway. Initially samples of treatment centers, hospitals, prisons, and other places where drug abusers are known to frequent will be surveyed in a few selected geographic areas. Subsequently, this may be expanded to larger areas. The intention is to use modeling in conjunction with this sampling data to estimate hard core drug use. It may be possible to add questions on the use of uncontaminated drug paraphernalia to the sample instruments. Measurement and tracking would then be possible through the use of combined modeling and sampling efforts.

Objective 18.07: Reduce to no more than 1 per 250,000 units of blood and blood components the risk of transfusion-transmitted HIV infection.

COMMENTARY

No changes are proposed.

Midcourse Review, Healthy People 2000

Objective 18.08: Increase to at least 80 percent the proportion of HIV-infected people who have been tested for HIV infection and who know their status.

COMMENTARY

The following one-time note is proposed: The intent in tracking this objective is track an indicator of the effectiveness of programs designed to reach high risk individuals and to counsel them on ways to change their behaviors so as to lower their risk of becoming infected or to lower their risk of transmitting the virus, if they were already infected. Changes in the behavior of this latter group, infected people, can have the most profound effect on the incidence of infections as this is the only group that is capable transmitting the virus. However, if members of this group, do not know they are infected, this is a mute point from the perspective of prevention. The addition of the phrase "and who know their serostatus" is intended to make it clearer that testing for testing's sake is not a goal. The goal is to identify and change the behavior of people at elevated risk to acquire or transmit the virus. Note that the wording in the first sentence of this statement could cause confusion as the objective addresses only those who are already infected, not all high risk people. Can the intent be made clearer? Or, should reference to infected people be dropped?

Measurement of this objective is very problematic. The data we have are from publicly funded clinics. Data with sufficient rigor to extrapolate from the data we have to the objective are not available. The data that are available, however, can be used to track the objective, as revised, without additional loss of coverage. Nonetheless, this change still raises an issue: Does this change result in a new single indicator (i.e., test and know status) or does this change result in an addition indicator (i.e., the percentage of those tested or the percentage of those who are infected who were told their status)?

Objective 18.09: Increase to at least 75 percent the proportion of primary care and mental health care providers* who provide ~~age-~~appropriate** counseling on the prevention of HIV and other sexually transmitted diseases.

Subpart a. Providers practicing in high incidence areas	Increase to 90 percent

* Primary care providers include physicians, nurses, physician assistants, and nurse practitioners. Mental health care providers include psychiatrists, psychologists, social workers, and psychiatric nurses.

** Appropriate counseling is defined as counseling that is client centered and sensitive to issues of age or development stage, gender, race, ethnicity, culture, language, and sexual orientation.

COMMENTARY

The definitions of "primary care and mental health care providers" as well as the definition of "appropriate" are proposed for addition to bring additional rigor to the objective.

"Age" appropriate was thought to be inadequate to the goal of the objective. If counseling is to be effective, it must be more than "age" appropriate. It must be appropriate for all the factors listed in the proposed new text, including age.

Does the definition of "appropriate" counseling belong in the HIV chapter? It is thought that this definition has universal utility throughout the HP2000 documents. Rather than the footnote approached employed above, a recommendation that ODPHP include the definition in its preference material may be a better approach.

This objective is repeated in HP 2000 chapter 19, sexually transmitted diseases. There will be a need to coordinate any change with that workgroup. STD has the lead.

Objective 18.10: Increase to at least 95 percent the proportion of schools that have ~~age~~-appropriate* HIV education curricula for students in 4th through 12th grade, preferably as part of comprehensive ~~quality~~ school health education.

* An appropriate curriculum is defined as one is sensitive to issues of age or development stage, gender, race, ethnicity, culture, language, and sexual orientation.

COMMENTARY

"Age" appropriate was thought to be inadequate to the goal of the objective. If education is to be effective, it must be more than "age" appropriate. It must be appropriate for all the factors listed in the proposed new text, including age.

All similar objectives in other priority areas will be changing from "quality" school health education to "comprehensive" school health education."

With refinements to data collection that are to be implemented, it is anticipated we be able to track "schools," as is the goal of the objective, and not just "school districts," as is the current situation.

Given the situation that currently exists, the provision of HIV education in the secondary grades (grades 9-12) is less than it is in the elementary grades, grades 4-8, should there be a subpart to this objective that tracks the secondary grades? If adopted the text of the objective would not change, but the data reported would be for grades 9 through 12 as well as for either grades 4 through 8 or grades 4 through 12, depending on the data availability.

Objective 18.11: Provide HIV education for students and staff in at least 90 percent of colleges and universities.

COMMENTARY

Data to track this objective will be available in 1995. It will address "students" not "students and staff" as specified in the objective. The proposal is just to accept that we can track only "students."

Objective 18.12: Increase to at least 90 percent the proportion of cities with populations over 100,000 that have outreach programs to contact drug abusers (particularly injecting ~~intravenous~~ drug abusers) to deliver HIV risk reduction messages.

COMMENTARY

The major criticism of this objective is that a single program in a city of a million people counts the same as a city of 100,000 people. However, we need to keep in mind that a number of programs a city needs depends on a host of factors (eg, scope of the epidemic, geographic and demographic distributions). These are issues for local programs. It is proposed that, for tracking purposes, this is reasonable.

There is a proposal to rewrite the objective to read: Increase to at least 90 percent the proportion of cities meeting the 1991 Substance Abuse Block Grant requirements for HIV set-aside that have outreach programs to deliver HIV risk reduction messages to drug abusers (particularly injecting drug abusers). However, while this change brings more rigor and definition to the text of the objective, many readers thought it was overly bureaucratic.

The requirement that a community planning process be implemented in communities receiving Federal support for HIV prevention should help us attain this objective.

Objective 18.13: Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that screen, diagnose, treat, counsel, and provide (or refer for) partner notification services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia).

COMMENTARY

This is probably the most complex of the HIV objectives in terms of data. However, if we can track just one or two types of clinics, that should be a reasonable "indicator." Currently data are available for family planning clinic only. We propose tracking STD and TB clinics as well.

This objective is repeated in Healthy People 2000 chapter 19, sexually transmitted diseases. There will be a need to coordinate any change with that workgroup. It has the lead.

Objective 18.14: Extend to all facilities where workers are at risk for occupational transmission of HIV regulations to protect workers from exposure to bloodborne infections, including HIV infection.

COMMENTARY

No need to modify this objective just because it has already been met. A number of the process objectives are of this nature.

ATTACHMENT TWO

Objective by Objective Review
Of Baseline Data

Midcourse Review, Healthy People 2000

Objective 18.01: Confine annual incidence of diagnosed AIDS cases to no more than 98,000 cases.

Subpart	a. Gay and bisexual men	No more than 48,000
	b. Blacks	No more than 37,000
	c. Hispanics	No more than 18,000

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
44,000-50,000	48,400	98,000	No change
Subparts			
26,000-28,000	27,800	48,000	No change
14,000-15,000	14,500	37,000	No change
7,000-8,000	8,200	18,000	No change

Objective 18.02: Confine the prevalence of HIV infection to no more than 800 per 100,000 people.

Subpart a.	Homosexual men	No more than 20,000
b.	Intravenous drug users	No more than 40,000
c.	Women giving birth to live-born infants	No more than 100

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
400/100,000	No Change	800/100,000	Not Applicable
Subparts			
2,000-42,000	15,000-61,000	20,000	Unclear
30,000-40,000	No Change	40,000	Not Applicable
150	No Change	100	Not Applicable

Objective 18.03: Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17.

Changes in Data

How This Objective Is Measured	Baseline			Result Of Proportional Adjustment
	Original	Revised	Target	
Girls by age 15	27 percent	No Change	15 percent	Not Applicable
Boys by age 15	33 percent	No Change	15 percent	Not Applicable
Girls by age 17	50 percent	No Change	40 percent	Not Applicable
Boys by age 17	66 percent	No Change	40 percent	Not Applicable

Objective 18.04: Increase to at least 50 percent the proportion of sexually active, unmarried people who used a condom at last sexual intercourse.

Subpart a.	Sexually active young women aged 15-19 (by their partners)	Increase to at least 60%
b.	Sexually active young men aged 15-19	Increase to at least 75%
c.	Intravenous drug abusers	Increase to at least 60%

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
19 percent[1]	No change	50 percent	Not applicable
Subparts			
26 percent	No Change	60 percent	Not Applicable
57 percent	No Change	75 percent	Not Applicable
No data available	No Change	60 percent	Not Applicable

1. Nineteen percent of sexually active, unmarried women, aged 15 to 44, reported that their partners used a condom at last sexual intercourse in 1988.

Objective 18.05: Increase to at least 50 percent the estimated proportion of all intravenous drug abusers who are in drug abuse treatment programs.

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
11 percent	No Change	50 percent	Not Applicable

Objective 18.06: Increase to at least 50 percent the estimated proportion of intravenous drug abusers not in treatment who use only uncontaminated drug paraphernalia ("works").

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
25-35 percent	30.8 percent	50 percent	No Change

Objective 18.07: Reduce to no more than 1 per 250,000 units of blood and blood components the risk of transfusion-transmitted HIV infection.

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
1/40,000-150,000	No Change	1/250,000	Not Applicable

Objective 18.08: Increase to at least 80 percent the proportion of HIV-infected people who have been tested for HIV infection.

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
15 percent	No Change	80 percent	Not Applicable

Objective 18.09: Increase to at least 75 percent the proportion of primary care and mental health care providers who provide age-appropriate counseling on the prevention of HIV and other sexually transmitted diseases.

Subpart a. Providers practicing in high incidence areas — Increase to 90 percent

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
10 percent[1]	No Change	75 percent	Not Applicable
Subpart			
No Data	No Change	90 percent	Not Applicable

1. Number refers to physicians. Objective refers to "primary care providers" which is defined to include also nurses, nurse practitioners, and physician assistants.

Objective 18.10: Increase to at least 95 percent the proportion of schools that have age-appropriate HIV education curricula for students in 4th through 12th grade, preferably as part of quality school health education.

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
66 percent	67 percent	95 percent	96.4 percent

Objective 18.11: Provide HIV education for students and staff in at least 90 percent of colleges and universities.

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
No Data	No Change	90 percent	Not Applicable

Objective 18.12: Increase to at least 90 percent the proportion of cities with populations over 100,000 that have outreach programs to contact drug abusers (particularly intravenous drug abusers) to deliver HIV risk reduction messages.

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
No Data	No Change	90 percent	Not Applicable

Objective 18.13: Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that screen, diagnose, treat, counsel, and provide (or refer for) partner notification services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia).

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	
40 percent[1]	No Change	50 percent	Not Applicable

Objective 18.14: Extend to all facilities where workers are at risk for occupational transmission of HIV regulations to protect workers from exposure to bloodborne infections, including HIV infection.

Changes in Data

Baseline			Result Of Proportional Adjustment
Original	Revised	Target	

1. The number refers only to family planning clinics for bacterial sexually transmitted diseases.