

Centers for Disease Control and Prevention

National HIV Prevention Progress Report, 2015

Includes data for 2006 through 2014
where available

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention



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Executive Summary

Reaching our nation's HIV prevention goals is essential for protecting and improving the health of all people who are at risk for or living with HIV infection. The Centers for Disease Control and Prevention (CDC) Division of HIV/AIDS Prevention (DHAP) Strategic Plan supports the four goals of the National HIV/AIDS Strategy for the United States (NHAS) related to: reducing new HIV infections; increasing access to care and improving health outcomes for people living with HIV; reducing HIV-related disparities and health inequities; and achieving a more coordinated national response to the HIV epidemic.

In 2013, CDC published the first National HIV Prevention Progress Report (NPR) to describe progress toward achieving the goals and objectives of the DHAP Strategic Plan for 2011-2015 (aligned with the NHAS goals for 2015). The report used data from CDC HIV surveillance systems to report on 21 key indicators. The first NPR served as a baseline report. This second NPR describes progress toward 2015 goals for 15 indicators adding additional data available for 2010-2014. Years of available data vary by indicator. The report highlights differences by age, gender, race/ethnicity, and HIV transmission risk—recognizing that progress among those disproportionately affected by HIV is important for achieving national goals and improving health equity.

In the NPR, progress toward achieving 2015 goals is evaluated against annual targets. These targets are based on the assumption that improvement will accelerate over time as more of the benefits of a high-impact approach to HIV prevention are realized. Achieving all of our nation's HIV prevention goals will not be easy. It is dependent upon progress at the local level and in groups that are disproportionately affected by HIV.

The updated NHAS uses HIV diagnoses rather than estimates of new infections as the indicator for monitoring progress toward reducing new infections. Incidence estimates are not published annually and estimation methods improve over time making it difficult to use estimated incidence as an indicator for measuring progress. HIV diagnosis data are published annually in a routine and standardized format, are available for all states, and can approximate incidence when HIV testing rates remain stable. Given these advantages, HIV diagnoses will be used as an indicator in future NPRs. CDC will periodically publish incidence data, but HIV incidence and transmission indicators have been retired.

Results available midway through the 5-year DHAP Strategic Plan period (2011-2015) show areas where we are making good progress and areas where we need to do better.

- **For 9 of 15 indicators (60%), annual targets were met.** HIV testing efforts have succeeded in increasing the percentage of people living with HIV who are aware of their infection. More persons with diagnosed HIV are being linked to HIV medical care and viral suppression has improved among persons in HIV medical care, including among gay, bisexual and other men who have sex with men (MSM) and blacks/African Americans. These results are encouraging and show progress along the HIV care continuum that will lead to better health for persons living with HIV and fewer new HIV infections.
- **For 3 of 15 indicators (20%), annual targets were not met but there was movement toward the target.** More work is needed to increase progress on linkage to HIV medical care among groups that are disproportionately affected by HIV especially blacks/African Americans and Hispanics/Latinos.
- **For 3 of 15 indicators (20%), annual targets were not met. There was no change or movement away from the target.** There is an urgent need to improve the effectiveness of HIV prevention efforts for MSM, people who inject drugs, and groups disproportionately affected by HIV. Increasing viral suppression among Hispanics/Latinos will require strategies to ensure retention in HIV medical care, early and effective treatment, and adherence to treatment.

Starting in 2016, the NPR will be revised to align with the updated NHAS for 2020 (released by the White House in July 2015) and the new DHAP Strategic Plan for 2016-2020. While some indicators will remain unchanged, some new ones will be added, others revised, and some retired. Key changes will include monitoring new HIV diagnoses rather than incidence; adding retention in HIV medical care and the death rate among persons with diagnosed HIV infection; and revising linkage to HIV medical care to within one month of diagnosis rather than 3 months. These updated indicators will support CDC efforts related to HIV prevention monitoring and program improvement.

Progress At-A-Glance

	2015 Goal	Current			
		Data Year	Annual Target	Result	Status
Prevent New HIV Infections					
Reduce new HIV infections by 25%		Indicator Retired*			
Increase knowledge of HIV-positive status to 90%	90.0%	2012	82.7%	87.2%	✓
Reduce late stage HIV diagnosis by 25%	18.9%	2013	22.7%	23.6%	→
Reduce the perinatal HIV transmission rate by 25%	4.8	2012	6.1	4.6	✓
Reduce sexual risk behavior among MSM by 25%	10.3%	2014	11.3%	15.7%	✗
Reduce sexual or injection risk behavior among PWID by 25%	54.8%	2012	69.4%	76.9%	✗
Increase Access to HIV Care and Improve Health Outcomes for People Living with HIV					
Reduce the HIV transmission rate by 30%		Indicator Retired*			
Increase linkage to HIV medical care to 85%	85.0%	2013	73.0%	82.1%	✓
Increase viral suppression among persons in HIV medical care by 10%	78.8%	2013	74.5%	80.1%	✓
Reduce sexual risk behavior among persons in HIV medical care by 33%	8.6%	2013	11.2%	10.7%	✓
Reduce HIV-Related Disparities and Health Inequities					
Reduce new HIV infections among groups at increased risk by at least 25%		Indicators Retired*			
— MSM, PWID, Blacks/African Americans, Hispanics/Latinos		Indicators Retired*			
Increase linkage to HIV medical care among all racial/ethnicity groups to 85% or greater					
— Blacks/African Americans	85.0%	2013	80.1%	79.0%	→
— Hispanics/Latinos	85.0%	2013	83.9%	83.0%	→
— Whites	85.0%	2013	84.1%	86.2%	✓
— Persons of other races/ethnicities	85.0%	2013	81.4%	83.6%	✓
Increase viral suppression among specific groups by at least 20%					
— MSM with diagnosed HIV	49.8%	2012	43.2%	45.5%	✓
— Blacks/African Americans with diagnosed HIV	40.9%	2012	35.5%	39.0%	✓
— Hispanics/Latinos with diagnosed HIV	42.5%	2012	36.8%	35.6%	✗

✓ Met or exceeded current annual target

→ Not met—moved toward annual target in most recent data year

✗ Not met—no change or moved away from annual target in most recent data year

Annual Targets and Results represent the most currently available data. See Indicator Summaries and Technical Notes for additional information.

* Incidence estimates are not published annually and estimation methods improve over time making it difficult to use estimated incidence as an indicator for measuring progress. HIV diagnosis data are published annually in a routine and standardized format, are available for all states, and can approximate incidence when HIV testing rates remain stable. Given these advantages, HIV diagnoses will be used as an indicator in the NHAS updated to 2020 and in future NPRs. CDC will periodically publish incidence data, but HIV incidence and transmission indicators have been retired.

Introduction

Reaching our nation's HIV prevention goals is essential for protecting and improving the health of all people who are at risk for or living with HIV infection. The National HIV/AIDS Strategy for the United States (NHAS), published in 2010, represents the nation's first comprehensive plan for addressing HIV. In July 2015, the NHAS was updated to reflect outcomes expected to be achieved by 2020. However, the four goals of the NHAS remain unchanged:

- reducing new HIV infections;
- increasing access to care and improving health outcomes for people living with HIV;
- reducing HIV-related disparities and health inequities, and;
- achieving a more coordinated national response to the HIV epidemic.

The Centers for Disease Control and Prevention (CDC) Division of HIV/AIDS Prevention (DHAP) Strategic Plan supports the goals of the NHAS and provides a road map for CDC's response to domestic HIV. CDC's response includes supporting prevention programs, raising HIV awareness, tracking trends in HIV, and supporting prevention research. These activities are guided by CDC's high-impact prevention approach for aligning the most cost-effective and scalable interventions geographically and demographically with the burden of HIV. The approach is designed to maximize the impact of federal prevention dollars and further our collective progress toward achieving the goals of the NHAS. CDC works with partners in other federal, state, and local agencies to support proven strategies that can reduce the risk of acquiring or transmitting HIV and improve the health of people living with HIV.

In 2013, CDC published the first National HIV Prevention Progress Report (NPR) to describe progress toward achieving the goals and objectives of the DHAP Strategic Plan for 2011-2015 (aligned with the NHAS goals for 2015). The report used data from CDC HIV surveillance systems to report on 21 key indicators that address the goals of the NHAS. The first NPR served as a baseline report and described indicator trends before 2011; where data were available, results were provided for the first year of implementation of the DHAP Strategic Plan.

This second NPR describes progress toward 2015 goals for 15 indicators adding additional data available for 2010-2014. Six indicators that use HIV incidence data have been retired (see box). The years for which data are available vary by indicator. The report highlights differences by age, gender, race/ethnicity, and HIV transmission risk—recognizing that progress among those disproportionately affected by HIV is important for achieving national goals and improving health equity.

The updated NHAS uses HIV diagnoses rather than estimated new infections as the indicator for monitoring progress toward reducing new infections.

Beginning in 2016, new HIV diagnoses will replace estimated new HIV infections as the indicator for monitoring progress toward reducing new infections. Although HIV incidence estimates were used previously by the NHAS to measure reductions in new infections, incidence estimates are not published annually and therefore are not available to monitor progress on a yearly basis. In addition, the methodology used to estimate the number of new infections has changed, and likely will continue to improve over time due to changes in HIV testing technology and refined incidence estimation methods. These changes make it difficult to use estimated incidence as an indicator. HIV diagnosis data are published in a routine and standardized format, are available for all states, and can approximate incidence when HIV testing rates remain stable. Given these advantages, HIV diagnoses will be used as an indicator in the updated NHAS and in the DHAP Strategic Plan for 2016-2020 (expected to be released in early 2016). CDC will publish incidence data periodically, but indicators that use HIV incidence data have been retired.

Measuring Progress

The fifteen indicators in this report provide an objective way to assess progress toward achieving key HIV prevention goals. They provide feedback that guides CDC planning and program improvement activities. The data for these indicators come from three CDC HIV surveillance systems (see box). Accurate and timely reporting of indicator data from these systems remains a priority for CDC. In this NPR, updates to previously published results are presented where available for indicators based on data from the National HIV Surveillance System (NHSS). The updated results include more complete data and less data duplication.

This report evaluates progress by comparing results with annual targets. Targets are based on the assumption that change will occur over time and will accelerate with each passing year. They take into account time needed for program planning and start-up activities, and for effects of programmatic changes to be reflected in the data. For each indicator, a baseline year was identified as the starting point for setting annual targets. The following assumptions were used to measure annual progress toward 2015 goals: 5% of the total change would occur by 2011, 20% by 2012, 40% by 2013, 70% by 2014, and 100% by 2015. In this NPR, annual targets are revised for indicators with updated baseline year data (Perinatal HIV Transmission; HIV-Related Disparities and Health Inequities: Viral Suppression among Specific Groups with Diagnosed HIV). The Technical Notes provide additional information about the baseline, annual targets, and 2015 goal for each indicator, as well as the data sources and estimation methods used for measuring those indicators.

For each indicator, symbols are used to indicate where the current annual target was:



Met or exceeded current annual target



Not met—moved toward annual target in most recent data year



Not met—no change or moved away from annual target in most recent data year

This report does not use statistical tests to assess changes over time, differences between groups, or differences between the result and the target. Rather, it compares the current annual target and result to assess whether the target has been met. Additionally, it highlights subgroups for which the 2015 goal has already been met. Statistically significant change is not expected from each year to the next and may not always be necessary to achieve the 2015 goal. Additional data for some indicators are available in other publications and may include information about statistical significance.

CDC HIV Surveillance Systems: Data Sources for Indicators

National HIV Surveillance System. All 50 states, the District of Columbia, and 6 dependent areas report confirmed diagnoses of HIV and AIDS to CDC including demographic characteristics, transmission category, and initial immune status. For 2013 data, 28 jurisdictions had complete reporting to CDC of CD4 and HIV viral load test results for January through December 2013.

Medical Monitoring Project. MMP uses a three-stage sampling approach that is designed to produce nationally representative information about adults receiving HIV medical care in the United States. Data are collected for samples of patients at outpatient HIV medical care facilities. Since 2009, 16 states, 6 cities, and Puerto Rico have been funded to participate.

National HIV Behavioral Surveillance. NHBS conducts behavioral surveillance in rotating three-year cycles among three populations at high risk for HIV infection—MSM, persons who inject drugs, and heterosexuals at increased risk for HIV infection. Data are collected in US cities with a high burden of AIDS. As of 2011, 20 cities have been funded to conduct NHBS.

Federal Monitoring and Reporting Activities

Many of the indicators in this report are part of other federal performance monitoring and reporting activities. In the Indicator Summaries, the following symbols denote the activities for which each indicator is reported:



National HIV/AIDS Strategy—a comprehensive national plan with clear and measurable HIV prevention goals. The strategy has been updated to 2020. Future NPRs will be aligned with indicators in the updated strategy.



Government Performance and Results Act—holds federal agencies accountable for achieving results through goal setting and performance measurement. Results are reported with the President's annual budget request.



Healthy People 2020—science-based national objectives for improving the health of all Americans and measuring the impact of prevention activities.



Department of Health and Human Services (HHS) Core HIV Indicators—seven core indicators for monitoring HHS-funded HIV prevention and care services.



Some indicators are also used in two key CDC monitoring reports. The **State HIV Prevention Progress Report** highlights state progress on key indicators that address the goals of the NHAS and the DHAP Strategic Plan and for which state level data are available. **Prevention Status Reports** highlight for each of the 50 states and the District of Columbia the status of public health policies and practices that are designed to prevent or reduce 10 important public health problems, including HIV infection.

Summary of Results

Results available midway through the 5-year DHAP Strategic Plan period (2011-2015) show areas where we are making good progress and areas where we need to do better.

For 9 of 15 indicators (60%), annual targets were met.

- HIV testing efforts have succeeded in increasing the percentage of people living with HIV who are aware of their infection.
- HIV testing of pregnant women and effective HIV treatment for women living with the virus have contributed to a reduction in the rate of perinatally acquired HIV infection.
- More people are being linked to HIV medical care within 3 months after diagnosis, especially whites and persons of other races/ethnicities. Progress has been made increasing viral suppression among persons in HIV medical care and among MSM and blacks/African Americans with diagnosed HIV.
- These results are encouraging and show progress along the HIV care continuum that will lead to better health for persons living with HIV and fewer new HIV infections.

For 3 of 15 indicators (20%), annual targets were not met but there was movement toward the target.

- More work is needed to increase progress on linkage to HIV medical care among groups that are disproportionately affected by HIV especially blacks/African Americans and Hispanics/Latinos.

For 3 of 15 indicators (20%), annual targets were not met. There was no change or movement away from the target.

- There is an urgent need to improve the effectiveness of HIV prevention efforts for MSM, people who inject drugs, and other groups disproportionately affected by HIV.
- Increasing viral suppression among Hispanics/Latinos will require strategies to ensure retention in HIV medical care, early and effective treatment, and adherence to treatment.

Looking Forward

Achieving our nation's HIV prevention goals will result in fewer new HIV infections, increased access to care and improved health outcomes for people living with HIV, and reduced HIV-related disparities and health inequities. However, the road to reaching our goals will not be easy. Aided by CDC funding, health departments are in the process of implementing high-impact prevention activities but it will take time to fully realize the impact of cost-effective and scalable prevention strategies. While effective HIV treatment has made it possible for more people with HIV to live longer, healthier lives, it also means there are more people living with HIV in need of HIV medical care and prevention services.

More than ever, monitoring HIV prevention indicators and actively using indicator data for program refinement and improvement are essential. The NPR is a tool for supporting and informing that process. It raises awareness about our nation's progress toward 2015 goals. It highlights areas where we are doing well and areas where more improvement is needed. The NPR complements the CDC State HIV Prevention Progress Report (SPR), which monitors the progress of each of the 50 states and the District of Columbia related to key HIV prevention and care indicators for which data are available at the state level.

Starting in 2016, the NPR will be revised to align with the updated NHAS for 2020 (see box) and the new DHAP Strategic Plan for 2016-2020. While some indicators will remain unchanged, some new ones will be added, others revised, and some retired.

One key change will be monitoring new HIV diagnoses rather than HIV incidence. Disparities in new diagnoses will be assessed using the rate of new diagnoses for specific groups—MSM; young black MSM; black females; and persons living in the Southern United States. Other important changes will include monitoring retention in HIV medical care and the death rate among persons living with diagnosed HIV infection; revising linkage to HIV medical care to within one month of diagnosis rather than 3 months; and assessing viral suppression among all persons with diagnosed HIV rather than among those in HIV medical care.

Future NPRs will focus on indicators in the new DHAP Strategic Plan for 2016-2020 which will include the following updated NHAS indicators.

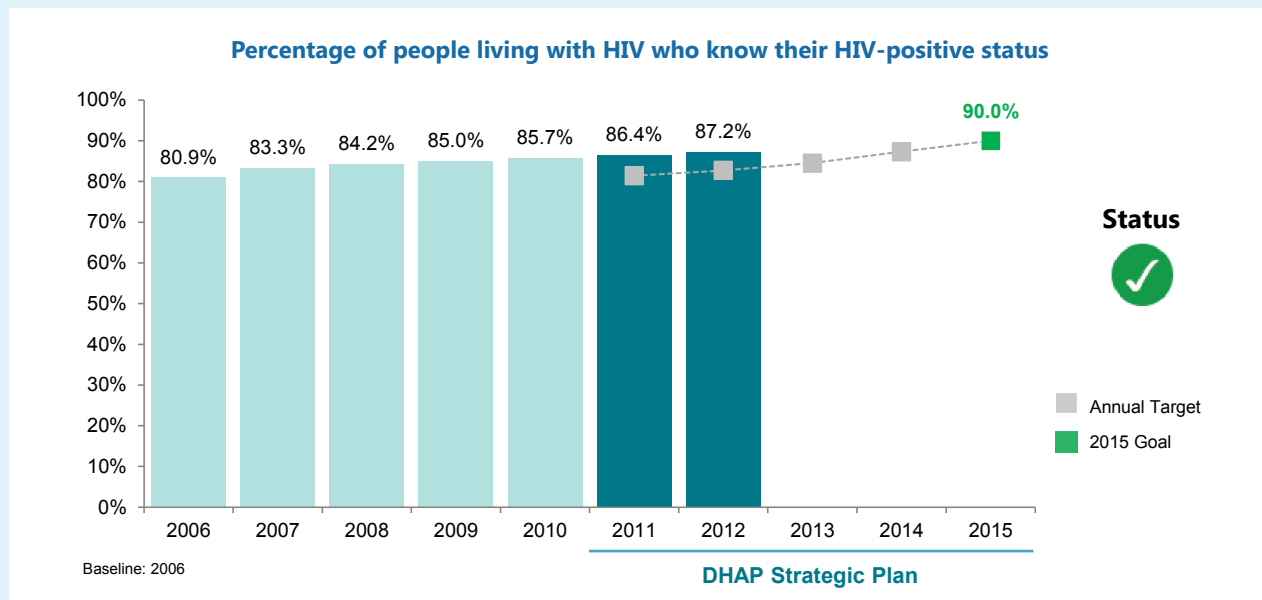
Indicator 1	Increase the percentage of people living with HIV who know their serostatus to at least 90%
Indicator 2	Reduce the number of new diagnoses by at least 25%
Indicator 3	Reduce the percentage of young gay and bisexual men who have engaged in HIV risk behaviors by at least 10%
Indicator 4	Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%
Indicator 5	Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90%
Indicator 6	Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%
Indicator 7	Reduce the percentage of persons in HIV medical care who are homeless to no more than 5%
Indicator 8	Reduce the death rate among persons with diagnosed HIV infection by at least 33%
Indicator 9	Reduce disparities in the rate of new diagnoses by at least 15% in the following groups: gay and bisexual men, young Black gay and bisexual men, Black females, and persons living in the Southern United States
Indicator 10	Increase the percentage of youth and persons who inject drugs with diagnosed HIV infection who are virally suppressed to at least 90%





Indicator Summaries

Increase Knowledge of HIV-Positive Status to 90%



People living with HIV need to know their HIV status to receive medical care, stay healthy, and reduce their risk for transmitting the virus to others. HIV testing efforts have succeeded in increasing the number of persons who are aware of their infection.

From 2007 to 2012, the percentage of people living with HIV who had been diagnosed (and who are assumed to know about their HIV infection) increased from 83.3% to 87.2%, with improvement reported each year¹. The 2012 target (82.7%) was met; we are on track for meeting the 2015 goal (90.0%).

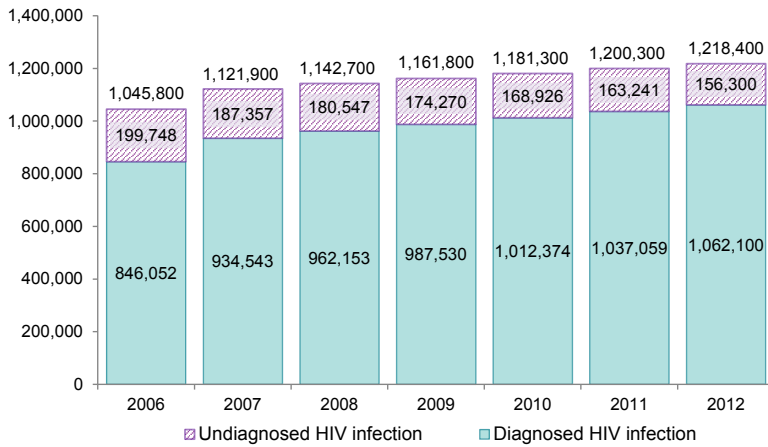
Results improved each year from 2007 to 2012. By 2012, 7 of 8 people living with HIV had been diagnosed.

Among subgroups, diagnosis of HIV infection improved from 2007 to 2012 among young people aged 13-24 years (30% increase) and among most transmission risk groups. The 2015 goal (90.0%) has been met for males and females with infection attributed to injection drug use; gay, bisexual and other men who have sex with men (MSM) with infection attributed to injection drug use; and persons aged 45 years and older. The percentage of people with undiagnosed HIV infection remains highest among those under 35 years of age, MSM, and heterosexual males and females.

Action Needed: As the number of people with undiagnosed HIV infection becomes smaller, making each new diagnosis will be harder, creating additional challenges for testing programs. However, increased health insurance coverage for HIV testing as a result of the Affordable Care Act may improve access. And HIV testing may increase if more providers adopt current CDC and US Preventive Services Task Force recommendations for routine HIV screening among adults and adolescents where prevalence of undiagnosed infections is $\geq 0.1\%$ and for at least annual screening for persons likely to be at increased risk (e.g., MSM, persons who inject drugs).

Data Source: National HIV Surveillance System (NHSS). See Technical Notes for additional information.

¹ This report includes 2006 baseline data reported previously and updated data for 2007-2012. Comparisons are made between 2007 and 2012, the years for which updated data are available.

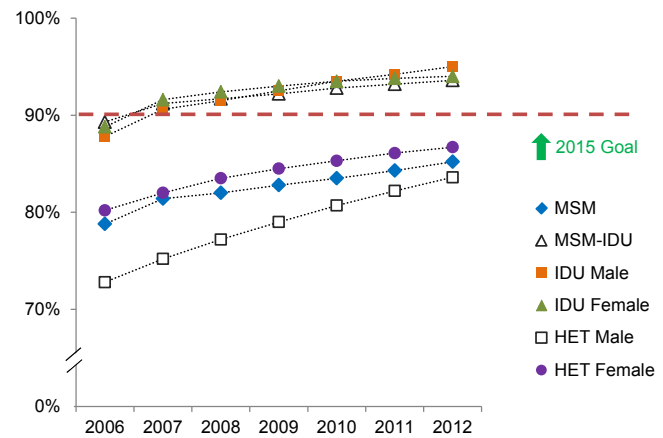


Fewer people have undiagnosed HIV infection

The total number of people living with HIV (HIV prevalence) increased 9% from 1,121,900 in 2007 to 1,218,400 in 2012. Even though HIV prevalence increased, the number of people with undiagnosed HIV infection decreased 17% from 187,357 in 2007 to 156,300 in 2012. More than 1 million people living with HIV had been diagnosed as of 2012.

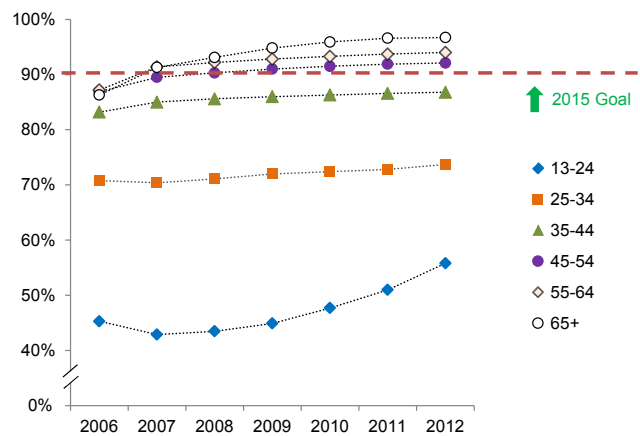
Knowledge of HIV-Positive Status by Transmission Risk

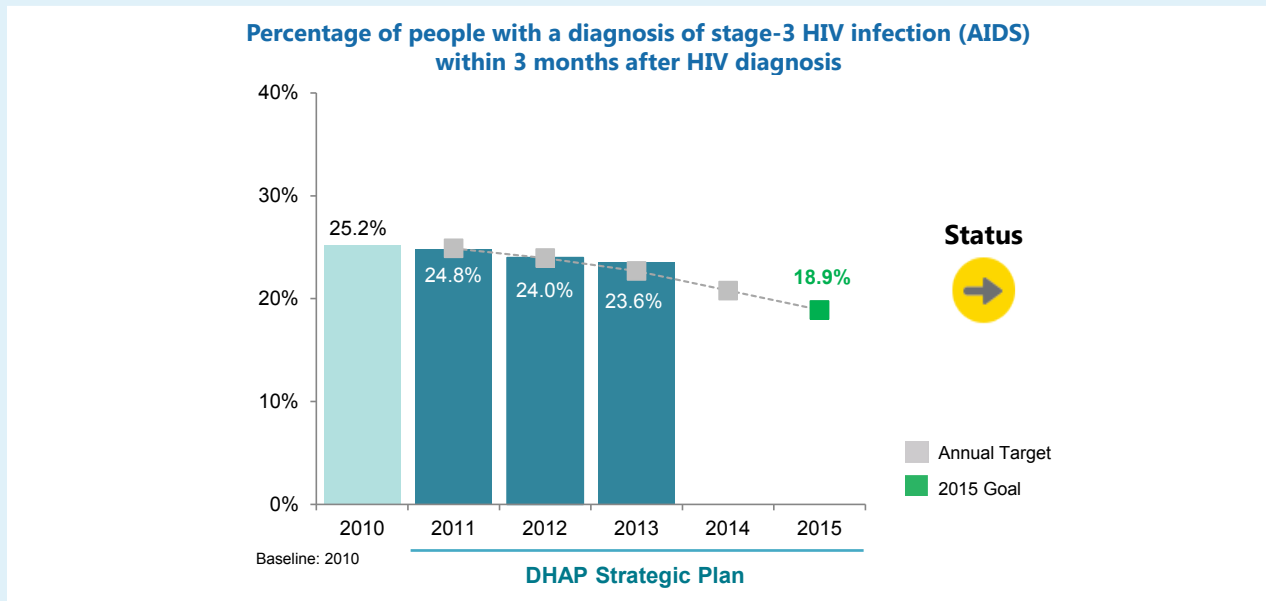
- The percentage of people living with diagnosed HIV improved in most transmission risk groups from 2007 to 2012. Among heterosexual males, the percentage with diagnosed HIV increased 11% from 2007 to 2012.
- The 2015 goal (90.0%) was met for males and females with infection attributed to injection drug use, and for MSM with infection attributed to injection drug use (MSM-IDU) each year during 2007-2012.



Knowledge of HIV-Positive Status by Age

- From 2007 to 2012, the greatest increase in diagnosis of HIV was among young people aged 13-24 years (30%).
- Despite this improvement, young people aged 13-24 years living with HIV are least likely of all age groups to know they are infected with HIV. This may be because they may have been infected more recently and have had less time to be tested and have their infection diagnosed compared to older adults.
- Diagnosis of HIV remained fairly stable among persons aged 35-64 years. There was slight improvement among 25-34 year olds (5%) and persons aged 65 years and older (6%).
- The 2015 goal (90.0%) was met for people aged 45 years and older each year during 2008-2012.





Diagnosis in the early stages of HIV infection improves the health and survival of people living with HIV and reduces HIV transmission. People with HIV infection diagnosed at an advanced stage of disease have most likely been infected for many years and represent missed opportunities to diagnose and treat the infection and to prevent transmission to others.

From 2010 to 2013, the percentage of people with HIV diagnosed at a late stage decreased 6%, from 25.2% to 23.6%. The 2013 target (22.7%) was not met, but there was movement toward the annual target.

Late HIV diagnoses are declining, but about 1 of 4 people living with HIV receive a late diagnosis.

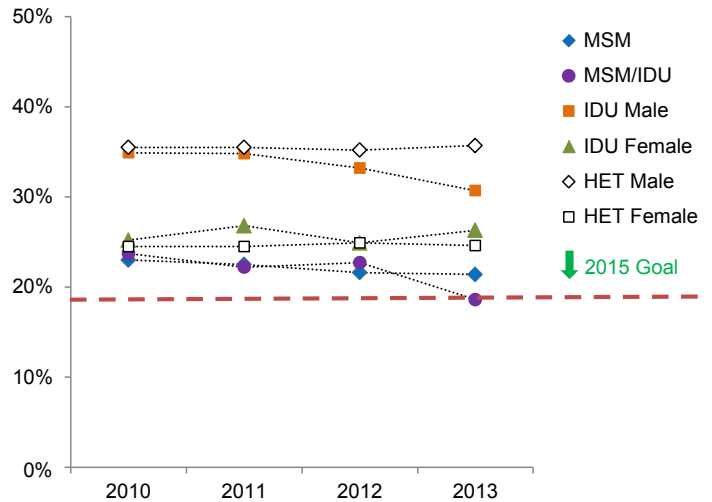
Groups with the highest percentage of persons with HIV diagnosed at a late stage include heterosexual males, males with infection attributed to injection drug use, and persons aged 35 years and older. Among race/ethnicity groups, diagnosis at a late stage declined from 2010 to 2013 among Native Hawaiians and Other Pacific Islanders (15%), Hispanics/Latinos (9%), blacks/African Americans (6%), and whites (6%). By gender, diagnosis at a late stage declined 8% among males and remained stable among females. In 2013, the 2015 goal (18.9%) was met for gay, bisexual and other men who have sex with men with infection attributed to injection drug use (MSM-IDU) and persons under 35 years of age.

Action Needed: To achieve the 2015 goal, widespread implementation of routine HIV screening is necessary. The greatest improvement is needed among heterosexual men, men with infection attributed to injection drug use, and persons aged 35 years and older.

Data Source: National HIV Surveillance System (NHSS). See Technical Notes for additional information.

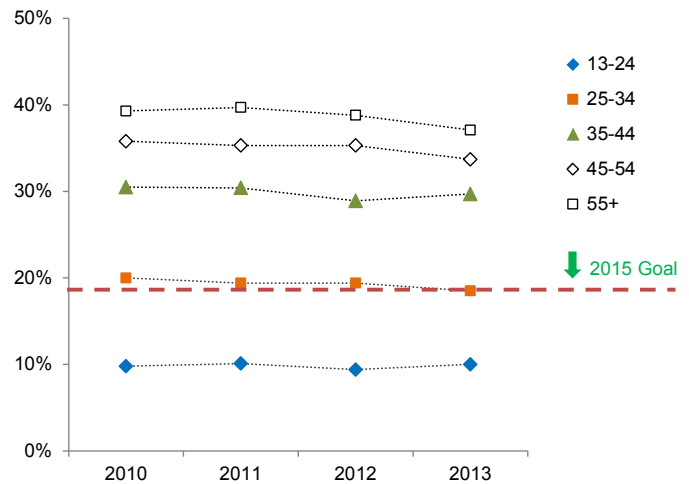
Late-Stage HIV Diagnosis by Transmission Risk

- From 2010 to 2013, there was a 22% decrease in late stage diagnosis among MSM with infection attributed to injection drug use (MSM-IDU).
- There was a 12% increase among females with infection attributed to injection drug use and a 7% decrease among MSM, during this time. Late stage diagnosis remained stable among other transmission risk groups.
- The 2015 goal (18.9%) was met among MSM-IDU in 2013.

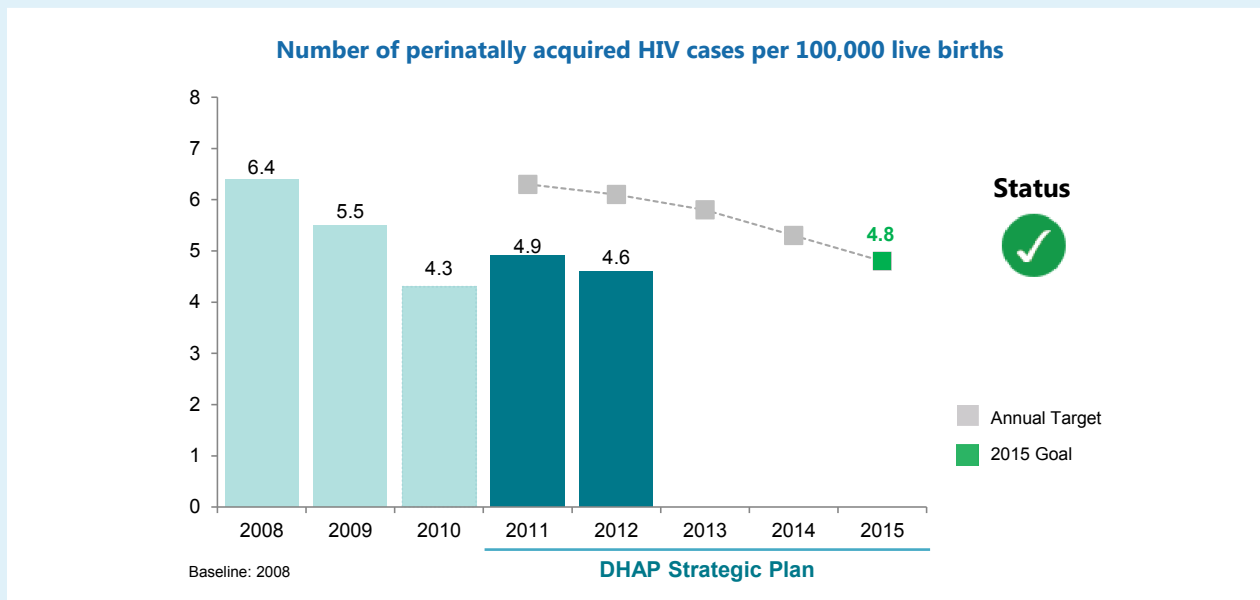


Late-Stage HIV Diagnosis by Age

- From 2010 to 2013, the percentage of people with a late stage diagnosis was fairly stable within all but two age groups. Late stage diagnosis decreased 8% among 25-34 year olds, and 6% among persons 45 years and older.
- The percentage of people with HIV diagnosed at a late stage increases with age.
- The 2015 goal (18.9%) was met among young people aged 13-24 years from 2010 to 2013. The goal was met among 25-34 year olds in 2013.



Reduce Perinatal HIV Transmission by 25%



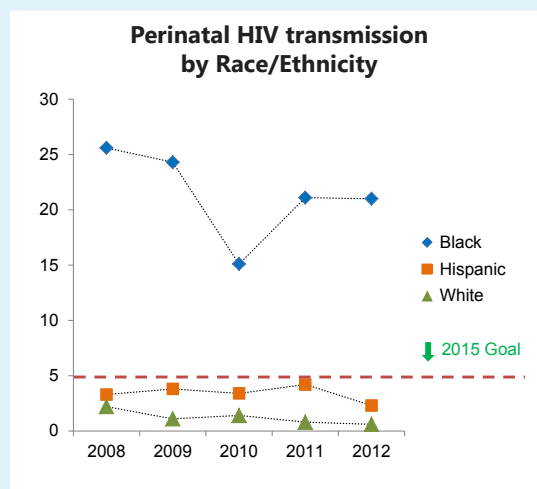
Perinatal HIV transmission from mother to child can occur during pregnancy, labor and delivery, or breastfeeding. The perinatal HIV transmission rate measures the number of infants with perinatally acquired HIV infection per 100,000 live births. HIV testing of pregnant woman, and effective HIV treatment for women living with the virus, have contributed to the decline in the number of infants who were perinatally infected with HIV.

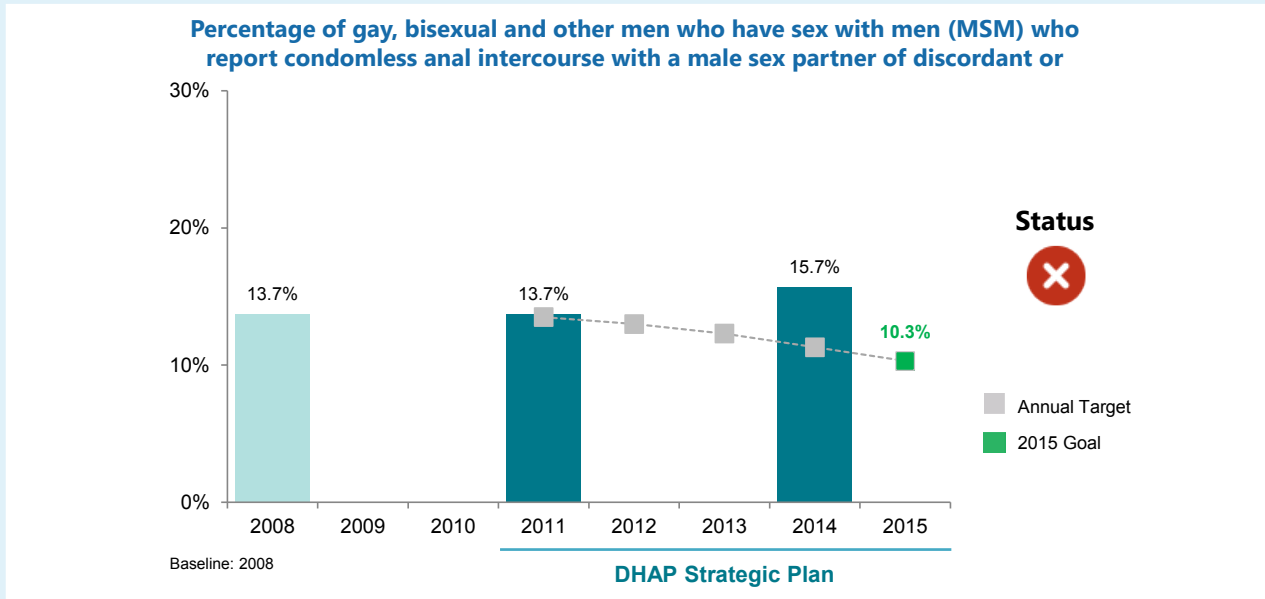
Perinatal HIV transmission continues to decline, but rates remain high among black/African American women and their infants.

In 2012, an estimated 181 infants acquired HIV perinatally, which is equivalent to 4.6 HIV cases per 100,000 live births. This reflects a 28% reduction in the rate of perinatally acquired HIV infection from 2008 to 2012. Much of this decrease occurred during 2008 through 2010. The 2012 target (6.1) was met. We are on track for meeting the 2015 goal (4.8).

From 2008 to 2012, perinatal HIV infection was consistently higher among black/African American infants than among Hispanic/Latino or white infants. The rate among black/African American infants decreased 18% during this time. The 2015 goal (4.8) has been met since 2008 among white and Hispanic/Latino infants.

Action Needed: Perinatal HIV transmission remains unacceptably high among blacks/African Americans. HIV testing and treatment of HIV infection needs to increase among black/African American women of reproductive age to reduce HIV transmission.





Having anal sex without using a condom is a risky behavior for HIV infection—especially if other highly effective risk reduction strategies such as pre-exposure prophylaxis (PrEP) and antiretroviral treatment of HIV infection are not used. It is important that gay, bisexual, and other men who have sex with men (MSM) lower their HIV risk by using one or more existing prevention strategies. This indicator measures condomless anal sex only. CDC also collects data on the use of other prevention strategies and is exploring how best to use these data in future reports.

Among MSM, anal sex without a condom with a discordant or unknown HIV status partner increased from 2008 to 2014.

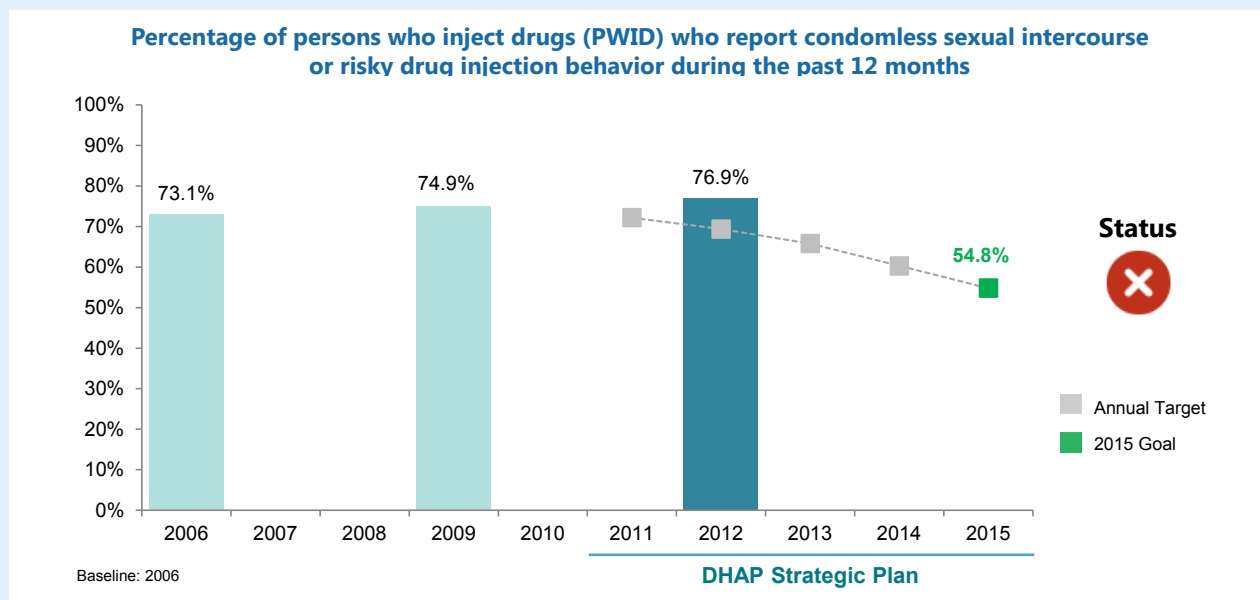
Every three years, CDC collects data about sexual risk behaviors among MSM in selected cities. Comparing 2008 and 2014, the percentage of MSM who reported having condomless anal sex with a discordant or unknown HIV status partner during their last sexual encounter increased 15% from 13.7% to 15.7%. The 2014 target (11.3%) was not met and there was movement away from the target. This indicator will not be assessed in 2015 because data will not be available.

The percentage change in condomless anal sex from 2008 to 2014 varied across subgroups. By age, condomless sex increased 12% among MSM aged 18-24 years; 19% among those aged 30-39 years; 28% among those aged 40-49 years; and 22% among those 50 years and older. Across race/ethnicity groups, condomless sex increased for Asians/Native Hawaiians and Other Pacific Islanders (26%); whites (19%); blacks/African Americans (9%); and Hispanics/Latinos (8%). In 2014, the 2015 goal (10.3%) was met for American Indian/Alaska Native MSM and Asian/Native Hawaiian and Other Pacific Islander MSM. The 2015 goal was not met for any age group.

Action Needed: There is an urgent need to improve the effectiveness of HIV prevention efforts for all MSM, especially young, racial/ethnic minority MSM, and MSM living with HIV. These efforts should aim to increase the use of condoms and other highly effective risk reduction strategies like PrEP and antiretroviral treatment for persons living with HIV. Too few gay and bisexual men in the United States are using these strategies consistently. Increasing condom use during anal sex, especially with partners whose HIV status is not known or whose viral load is not suppressed, remains an important public health goal.

Data Source: National HIV Behavioral Surveillance (NHBS). See Technical Notes for additional information.

Reduce Sexual or Injection Risk Behavior among PWID by 25%



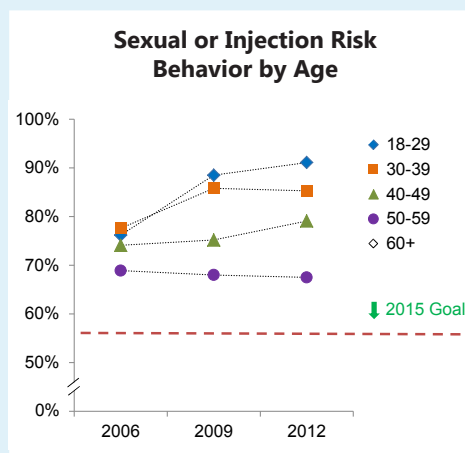
Sexual intercourse without a condom and use of non-sterile injection equipment both put people who inject drugs (PWID) at increased risk for acquiring and transmitting HIV, especially if other highly effective risk reduction strategies such as pre-exposure prophylaxis (PrEP) and viral suppression among partners with HIV are not used. Every three years, CDC collects data about sexual and drug use behaviors among PWID in selected cities. For this indicator, risky sexual behavior is defined as condomless vaginal or anal sex with a partner of the opposite sex, regardless of HIV status; risky drug use behavior is defined as using a syringe that had been used by someone else. Other strategies that are not monitored by this indicator, such as the use of PrEP, can also reduce the risk of HIV among PWID.

From 2006 to 2012, the percentage of PWID reporting condomless sex or syringe sharing in the past 12 months increased 5% from 73.1% to 76.9%. In 2012, about 1 of 3 PWID (30%) reported sharing syringes; 70% reported condomless vaginal sex and 25% reported condomless anal sex in the past 12 months. The 2012 target (69.4%) was not met. Much improvement will be needed to reach the 2015 goal (54.8%).

Differences were found among subgroups. Risk behavior as measured by this indicator increased 28% for Hispanics/Latinos who inject drugs from 2006 to 2012 but remained stable for other race/ethnicity groups. By age, condomless sex and/or syringe sharing increased 20% among persons aged 18-29 years who inject drugs; 10% among those aged 30-39 years; and 7% among those aged 40-49 years. These risks increased 9% among males who inject drugs and 3% among females who inject drugs. In 2012, no group had met the 2015 goal (54.8%). Persons under 40 years of age who inject drugs, especially those aged 18-29 years, were furthest from the goal.

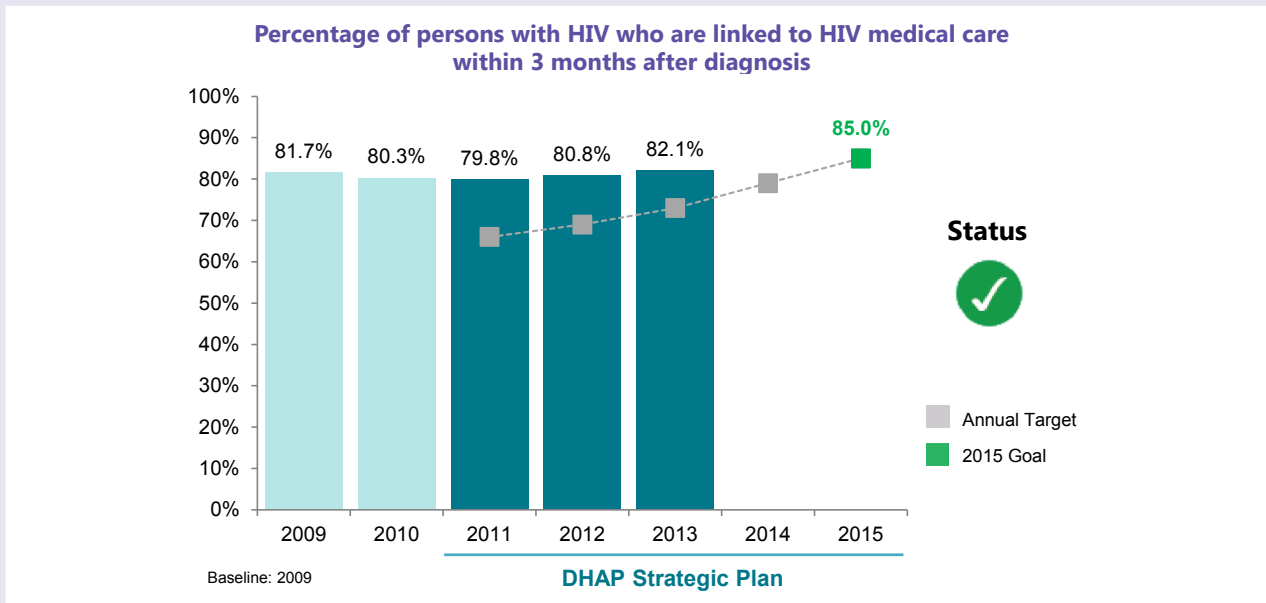
Action Needed: To achieve the 2015 goal, targeted and scaled combination HIV prevention strategies—including access to and use of condoms, drug treatment and access to sterile needles and syringes, pre-exposure prophylaxis, antiretroviral treatment for those infected, and risk-reduction counseling—are needed for people who inject drugs. Stigma related to drug use, and social and economic factors that affect access to HIV treatment (e.g., homelessness, incarceration, lack of insurance), must also be addressed.

Sexual and drug injection risk behaviors have increased among people who inject drugs, especially young people



Data Source: National HIV Behavioral Surveillance (NHBS). See Technical Notes for additional information.

Increase Linkage to HIV Medical Care to 85%



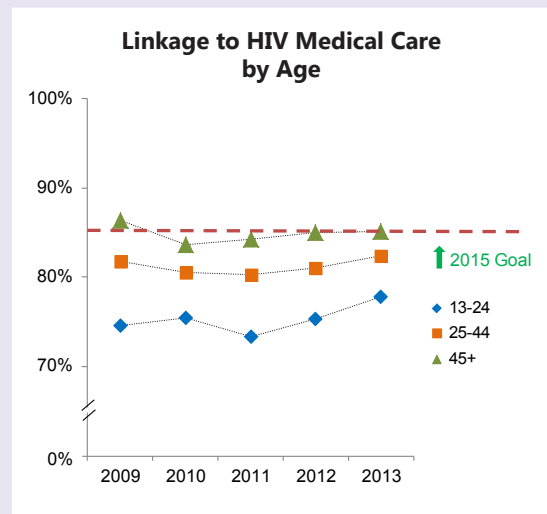
Linking people to HIV medical care immediately after diagnosis is essential for maximizing the benefits of early treatment and reducing the risk of transmission to others. CDC monitors linkage to HIV medical care using laboratory data from areas with complete reporting of CD4 and viral load test results. The number of areas meeting this criterion increased from 13 for 2009 to 28 for 2013. People who had a CD4 or viral load test within 3 months after diagnosis are considered linked to HIV medical care.

More progress is needed linking people to HIV medical care. 1 of 5 persons with HIV were not linked to HIV medical care within 3 months after diagnosis in 2013.

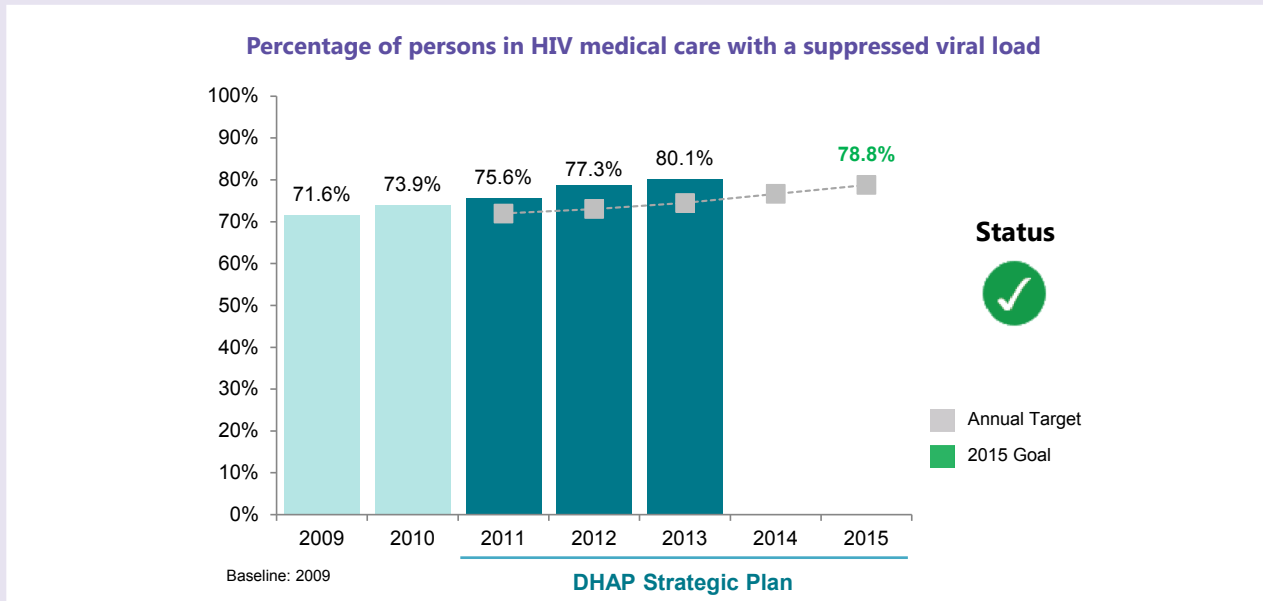
From 2009 to 2013, the overall trend in linkage to HIV medical care remained stable. Results were similar when the analysis was limited to areas with complete reporting for all 5 years. The 2013 target (73.0%) was met, but the low NHAS baseline (65%) yielded easy-to-reach targets. More improvement will be needed to reach the 2015 goal of 85.0%.

Linkage to HIV medical care remained stable across age, gender, race/ethnicity, and transmission risk subgroups—with the exception of a 10% decline among males who inject drugs and a 4% decline among 13-24 year olds. Since 2012, the 2015 goal (85.0%) has been met among people aged 45 years and older. Young people aged 13-24 years, blacks/African Americans, and people who inject drugs are furthest from the 2015 goal.

Action Needed: To achieve the 2015 goal, HIV testing programs need protocols and strategies for ensuring linkage to HIV medical care especially among young people, blacks/African Americans, and people who inject drugs. Complete reporting of CD4 and viral load test results is needed from all areas to improve monitoring of linkage to care at the local, state and national level.



Data Source: National HIV Surveillance System (NHSS). See Technical Notes for additional information.



The ultimate goal of HIV treatment is to achieve viral suppression, meaning the amount of HIV in the body is very low or undetectable. This is important for people with HIV to stay healthy, live longer and reduce their chances of passing HIV to others. A person’s viral load is suppressed when the results of a viral load test show that HIV is undetectable or that there are fewer than 200 copies of HIV per milliliter of plasma.

From 2009 to 2013, the percentage of persons in HIV medical care who had achieved viral suppression increased by 12%, from 71.6% to 80.1%. The 2013 target (74.5%) was met and exceeded. In 2013, the 2015 goal for the nation (78.8%) was met.

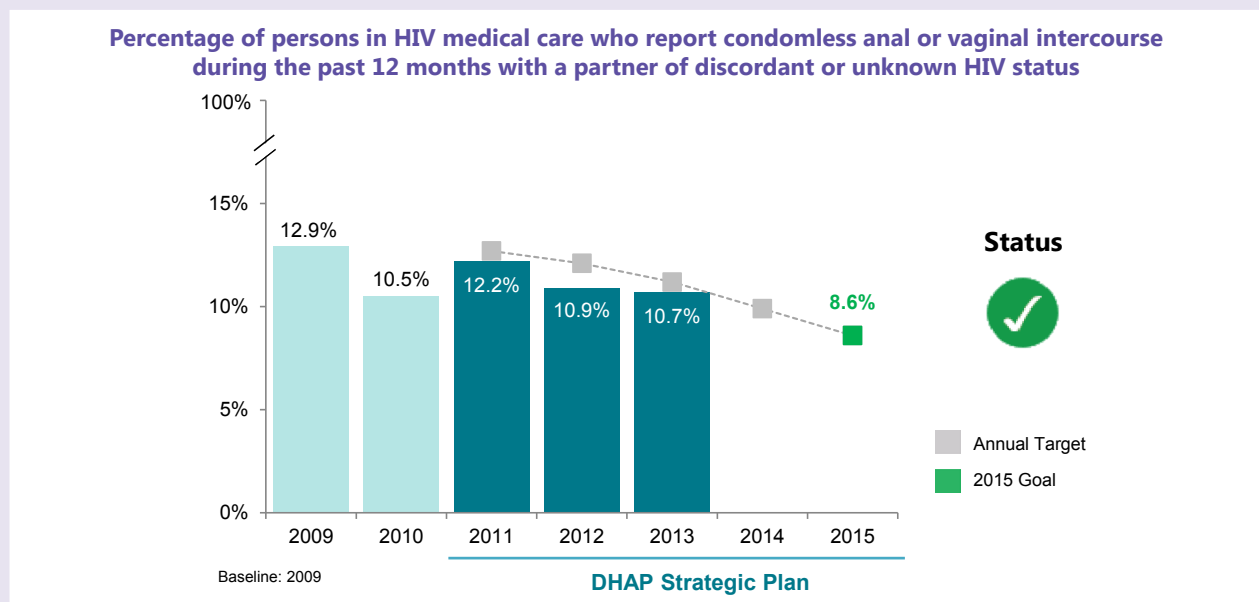
Viral suppression has increased among persons in HIV medical care. 4 of 5 persons in care had a suppressed viral load in 2013.

Viral suppression improved across all subgroups from 2009 to 2013 but the amount of improvement varied. By gender, viral suppression increased 24% among transgender persons in care, 16% among females, and 10% among males. Among race/ethnicity groups, there was an 18% increase among blacks/African Americans followed by persons of other races/ethnicities (14%), Hispanics/Latinos (9%) and whites (8%). The greatest increase by transmission risk was among persons who inject drugs (27%) followed by heterosexual females (16%), heterosexual males (14%) and gay, bisexual and other men who have sex with men (MSM) (9%). Improvements in viral suppression ranged from 20% among 18-29 year olds, 22% among those aged 30-49 years, and 6% among those aged 50 years and older.

In 2013, viral suppression was highest among whites in HIV medical care (86.0%), transgender persons (84.5%), and those 50 years and older (83.9%); it was lowest among young people aged 18-29 years (67.5%), persons who inject drugs (74.1%) and blacks/African Americans (75.5%). Several groups met the 2015 goal of 78.8% in 2012 including MSM, heterosexual males, whites, and Hispanics/Latinos.

Action Needed: There is a need to establish seamless systems to link people to care immediately after diagnosis and support retention in care, as well as re-engagement in care where needed, to achieve and sustain viral suppression. Health care providers, health departments, community-based organizations, and people living with HIV need to continue to work together to increase retention in HIV medical care, early and effective HIV treatment, and adherence to HIV treatment.

Reduce Sexual Risk Behavior among Persons in HIV Medical Care by 33%



Condomless anal or vaginal sex between a person living with HIV and an uninfected partner results in a substantial number of HIV infections each year in the United States. CDC encourages all people living with HIV to use condoms during anal and vaginal sex, including those who are taking antiretroviral treatment that reduces transmission risk.

From 2009 to 2013, condomless anal or vaginal sex with a discordant or unknown HIV status partner in the past 12 months decreased 17% among persons in HIV medical care. In 2013, about 1 of 10 persons in HIV medical care (10.7%) reported condomless sex. The 2013 target (11.2%) was met. To meet the 2015 goal (8.6%), efforts to reduce condomless sex will need to improve at a quicker pace than previously achieved.

Condomless sex has decreased among persons in HIV medical care. Only 10% of people in care reported condomless anal or vaginal sex in 2013.

The decrease in condomless sex varied across subgroups. Among transmission risk groups, heterosexual males had the greatest decrease (24%) followed by heterosexual females (22%); gay, bisexual and other men who have sex with men (MSM) (11%); and persons who inject drugs (3%). By race/ethnicity, the greatest decrease was among blacks/African Americans (21%) followed by Hispanics/Latinos (17%), persons of other races/ethnicities (13%) and whites (11%). By age, young people aged 18-29 years had the greatest decrease (23%) followed by those 50 years and older (13%), 40-49 year olds (11%), and 30-39 year olds (10%). Condomless sex decreased 22% among females and 14% among males.

In 2013, condomless sex was lowest among persons with HIV aged 50 years and older (6.7%), heterosexual men (7.1%), and blacks/African Americans (8.4%). It was highest among person who inject drugs (26.6%), persons under 39 years of age (19.7% for 18-29 year olds and 18.1% for 30-39 year olds), and persons of other races/ethnicities (14.8%). The 2015 goal (8.6%) was met in 2012 for people aged 50 years and older and for heterosexual men. Persons who inject drugs were furthest from the goal.

Action Needed: To achieve the 2015 goal, individual and group-level interventions are needed to increase access to and use of condoms during anal or vaginal sex. Structural-level interventions—such as distributing free condoms in diverse venues, social marketing campaigns or policy change—can address the social, economic and political environments that affect condom availability and use. Access and adherence to HIV treatment and pre-exposure prophylaxis for uninfected partners are also critically important to reduce onward HIV transmission.

Data Source: Medical Monitoring Project (MMP). See Technical Notes for additional information.

HIV-Related Disparities and Health Inequities: Increase Linkage to HIV Medical Care among Specific Groups to 85% or Greater

People of all races/ethnicities need HIV medical care as soon as possible after receiving an HIV diagnosis to improve their health and reduce the risk of onward transmission of the virus. The unique needs and perspectives of members of specific race/ethnicity groups must be addressed to ensure that all individuals with diagnosed HIV are linked to HIV medical care without delay.

CDC monitors linkage to HIV medical care using laboratory data from areas with complete reporting of CD4 and viral load test results. The number of areas these data are based on doubled from 13 for 2009 to 28 for 2013. People who had a CD4 or viral load test within 3 months after diagnosis are considered linked to HIV medical care.

Linkage to HIV medical has not improved among any race/ethnicity group.

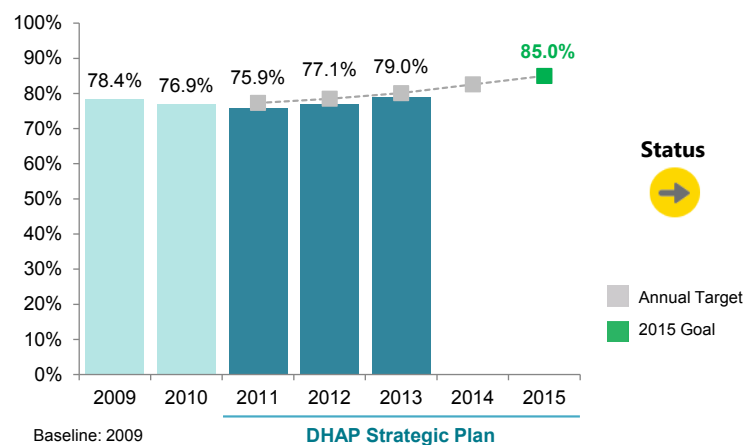
From 2009 to 2013, there was no improvement in linkage to HIV medical care among blacks/African Americans, Hispanics/Latinos or whites. Linkage to HIV medical care improved slightly (by 6%) among persons of other races/ethnicities during this time. In 2013, 86% of whites were linked to HIV medical care within 3 months after diagnosis followed by 84% of persons of other races/ethnicities, 83% of Hispanics/Latinos, and 79% of blacks/African Americans.

The 2013 target was met for whites and persons of other races/ethnicities. The 2015 goal has been met for whites since 2011. The 2013 target was not met for blacks/African Americans or Hispanics/Latinos though there was movement toward the target for these groups. More work will be needed to reach the 2015 goal of 85% especially for blacks/African Americans.

Action Needed: To achieve the 2015 goal, improved coordination and collaboration will be needed among health care providers, health departments, and community-based organizations to successfully link more people with HIV to HIV medical care. Linkage to medical care needs to happen as soon as possible after diagnosis.

Linkage to HIV Medical Care among Blacks/African Americans

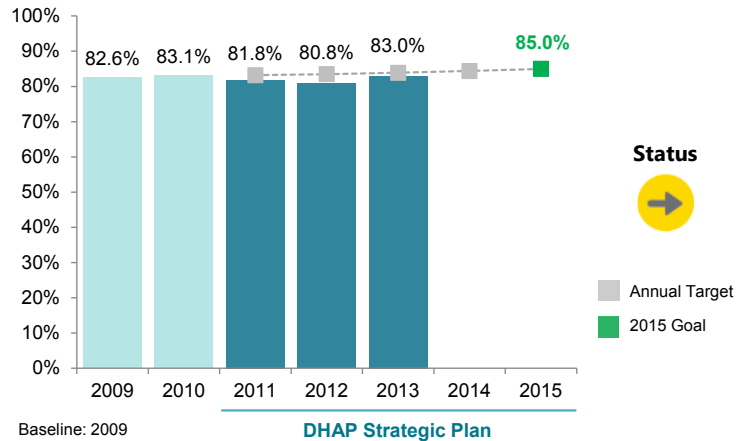
- Blacks/African Americans have the lowest percentage linked to HIV medical care among all race/ethnicity groups.
- In 2013, 79% of blacks/African Americans with HIV were linked to HIV medical care within 3 months after diagnosis.
- The percentage of blacks/African Americans linked to HIV medical care remained stable from 2009 to 2013.
- The 2013 target (80.1%) was not met although there was movement toward the target from 2012 to 2013.
- More work is needed to improve linkage to HIV medical care and achieve the 2015 goal of 85.0% among blacks/African Americans.



Data Source: National HIV Surveillance System (NHSS). See Technical Notes for additional information.

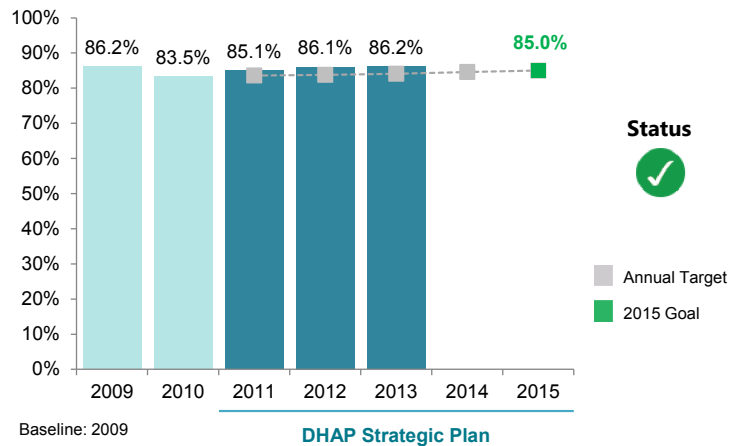
Linkage to HIV Medical Care among Hispanics/Latinos

- In 2013, more than 4 of 5 Hispanics/Latinos (83.0%) with HIV were linked to HIV medical care within 3 months after diagnosis.
- The percentage of Hispanics/Latinos with HIV who were linked to HIV medical care remained stable from 2009 to 2013.
- The 2013 target (83.9%) was not met although there was movement toward the target from 2012 to 2013.
- Continued effort is needed to reach the 2015 goal of 85.0% among Hispanics/Latinos.



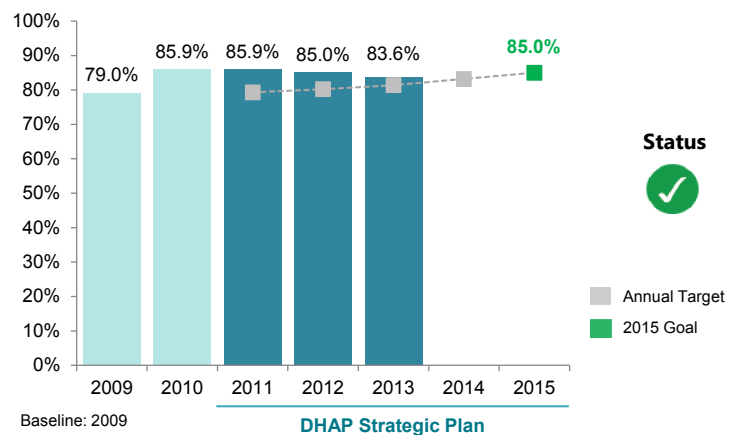
Linkage to HIV Medical Care among Whites

- In 2013, more than 4 of 5 whites (86.2%) with HIV were linked to HIV medical care within 3 months after diagnosis.
- Linkage to HIV medical care was stable among whites from 2009 to 2013.
- The 2013 target (84.1%) was met.
- Since 2011, the 2015 goal of 85% had been met among whites.



Linkage to HIV Medical Care among Persons of Other Races/Ethnicities

- In 2013, 83.6% of persons of other races/ethnicities with HIV were linked to HIV medical care within 3 months after diagnosis.
- There was a 6% increase in linkage to HIV medical care from 2009 to 2013 among persons of other races/ethnicities, although the percentage declined slightly from 2011 to 2013.
- The 2013 target (81.4%) was met. In 2013, the percentage linked to HIV medical care was 86.2% for American Indian/Alaska Natives, 85.3% for persons of multiple races, 82.4% for Asians, and 70.2% for Native Hawaiians/Other Pacific Islanders. [data not shown]
- In 2013, the 2015 goal of 85.0% was met among American Indian/Alaska Natives and persons of multiple races/ethnicities.



HIV-Related Disparities and Health Inequities: Increase Viral Suppression among Specific Groups by at least 20%

Establishing seamless systems to link people with HIV to HIV medical care immediately after diagnosis and support retention in care are essential for achieving viral suppression and maximizing the benefits of early treatment. This is especially important in communities that have the greatest burden of HIV.

CDC monitors viral suppression among people in HIV medical care (see page 15) and uses this information along with surveillance data on people living with an HIV diagnosis to estimate viral suppression among all HIV-diagnosed people. This includes those who are in HIV medical care and those who are not. The indicator of viral suppression estimates how many people with diagnosed HIV have an HIV viral load that is undetectable or fewer than 200 copies of HIV per milliliter of plasma.

Viral suppression has improved among MSM and blacks/African Americans. No improvement was found among Hispanics/Latinos.

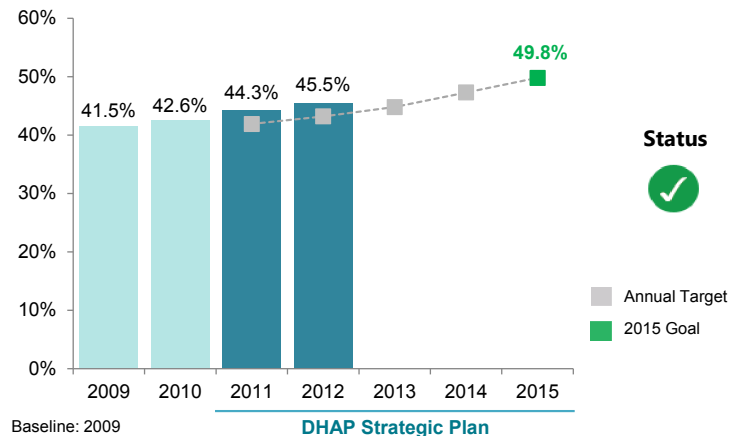
From 2009 to 2012, the overall percentage of people with a suppressed viral load increased by 10% from 37.8% to 41.7%. Trends in viral suppression varied across groups: improvements were seen among blacks/African Americans (14%) and MSM (10%). Viral suppression remained stable at 35% among Hispanics/Latinos.

The 2012 target was met for MSM and blacks/African Americans. With continued effort, the 2015 goal can be met for these groups. The 2012 target was not met for Hispanics/Latinos. More intensified effort will be needed to reach the goal for this group. As of 2012, no group had met the 2015 goal.

Action Needed: Increasing the number of people living with HIV in disproportionately affected communities who achieve and maintain viral suppression is essential for reducing disparities in HIV infection and mortality. Strategies are needed to improve linkage to HIV medical care, and retention in care, especially among Hispanics/Latinos. Efforts to address underlying social determinants of health, such as reducing stigma associated with HIV and increasing access to health care and supportive services, could increase timely HIV diagnosis, retention in care, treatment, and viral suppression.

Viral Suppression among MSM with Diagnosed HIV

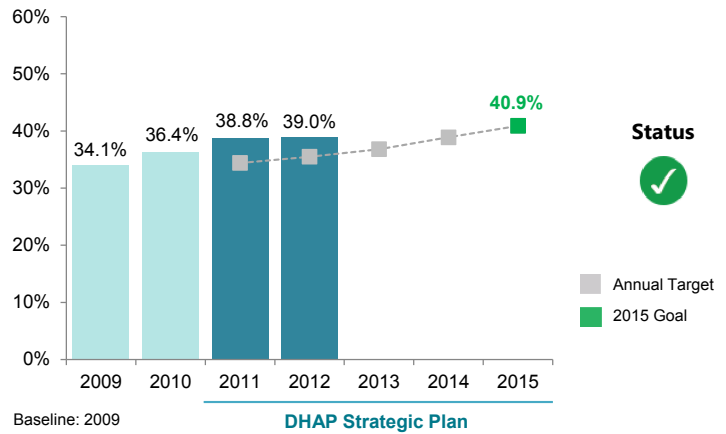
- From 2009 to 2012, viral suppression increased 10% among men with HIV infection attributed to male-to-male sexual contact.
- Nearly half of MSM with HIV had a suppressed viral load in 2012.
- The 2012 target (43.2%) was met among MSM.



Data Source: Medical Monitoring Project (MMP) and National HIV Surveillance System (NHSS). See Technical Notes for additional information.

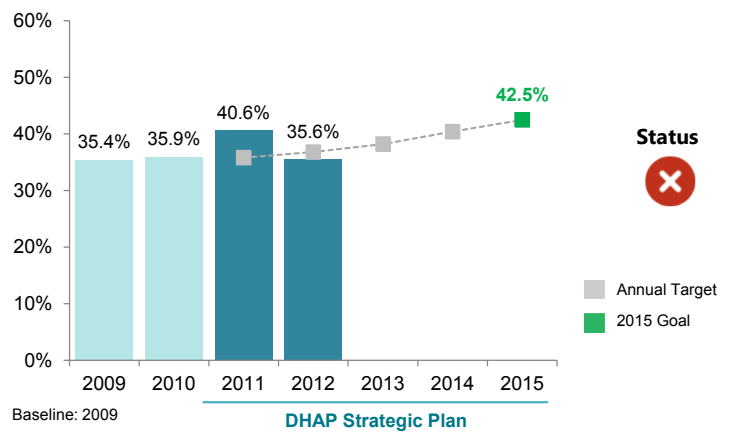
Viral Suppression among blacks/ African Americans with Diagnosed HIV

- From 2009 to 2012, the percentage of blacks/African Americans with HIV who had a suppressed viral load increased 14% from 34.1% to 39.0%.
- In 2012, more than 1 of 3 blacks/African Americans with HIV had a suppressed viral load.
- The 2012 target (35.5%) was met among blacks/African Americans.



Viral Suppression among Hispanics/ Latinos with Diagnosed HIV

- From 2009 to 2012, the percentage of Hispanics/Latinos with HIV who had a suppressed viral load remained stable at about 35%.
- In 2012, 35.6% of Hispanics/Latinos with HIV had a suppressed viral load.
- The 2012 target (36.8%) was not met among Hispanics/Latinos.





The background features a series of overlapping, semi-transparent, curved shapes in shades of green, blue, and purple. These shapes are layered, creating a sense of depth and movement. The colors transition from light green and blue on the left to darker blue and purple on the right. The overall composition is modern and clean.

Technical Notes

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Technical Notes

Increase Knowledge of HIV-Positive Status

Objective: By 2015, increase to 90% the percentage of people living with HIV who know their serostatus

Indicator: Percentage of HIV-infected persons aged 13 years and older who are aware of their HIV infection

Numerator: Estimated number of persons aged 13 years and older living with diagnosed HIV at year-end

Denominator: Estimated number of persons aged 13 years and older who were living with HIV infection in the United States at year-end. This includes those who had their HIV infection diagnosed as well as those whose HIV infection was undiagnosed.

Data Source: National HIV Surveillance System (NHSS)

Indicator Notes: HIV surveillance data for persons aged >13 years at diagnosis from the 50 states and the District of Columbia were used to estimate HIV prevalence (the total number of people living with HIV). An extended back-calculation model was used that considers the estimated annual number of HIV diagnoses, stage of disease at diagnosis, and the number of deaths among persons with HIV infection. The number of people living with HIV infection who are unaware of their infection is calculated by subtracting the number of people living with diagnosed HIV infection from the overall HIV prevalence estimate. This estimate is based on HIV diagnoses, not individual awareness of HIV status. Some people who were diagnosed with HIV may be unaware of their HIV status because they did not receive their test results. Differences between current and previous estimates of prevalence may be due to the availability of additional information, more complete data for previous years, the inclusion of additional years of data, or refinements in data adjustments and modeling.

Target Setting: The baseline year was established as 2006 in the National HIV/AIDS Strategy released in 2010 and was adopted for the DHAP Strategic Plan for 2011-2015. The updated 2006 estimate reported in 2013 (80.9%) was used as the baseline. The 2015 goal of 90.0% was set in NHAS. Annual targets assume an accelerating rate of change over time and were based on the following assumptions for the percentage of total change that was expected in a given year: 2011 (5% of total change); 2012 (15% of total change); 2013 (20% of total change); 2014 (30% of total change); 2015 (30% of total change). Based on these assumptions, the current annual targets are: 2011 (81.4%); 2012 (82.7%); 2013 (84.5%); 2014 (87.3%).

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CDC. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas—2013. HIV Surveillance Supplemental Report 2015;20(2). Published July 2015. http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillancereport_vol20_no2.pdf. Accessed October 2, 2015.

Reduce Late Stage HIV Diagnosis

Objective: By 2015, reduce by 25% the percentage of people with a diagnosis of stage-3 HIV infection (AIDS) within 3 months after HIV diagnosis

Indicator: Percentage of persons aged 13 years and older with HIV infection diagnosed at stage-3 (AIDS) within 3 months after initial HIV diagnosis

Numerator: Estimated number of persons aged 13 years and older with HIV diagnosed at stage-3 HIV infection (AIDS) within 3 months after initial HIV diagnosis in the calendar year

Denominator: Estimated number of persons aged 13 years and older with HIV infection diagnosed in the United States and 6 US dependent areas in the calendar year

Data Source: National HIV Surveillance System (NHSS)

Indicator Notes: In 2012, this objective and the indicator were revised to align with the new HHS core indicators,

¹ The United States refers to the 50 states and the District of Columbia. Where indicator data are available for the United States and US dependent areas, they are presented for the United States and US dependent areas. The Technical Notes provide the geographic specification for each indicator.

to reflect a decrease in the percentage of people with a late HIV diagnosis instead of an increase in the percentage of people with HIV diagnosed at earlier stages of disease. Stage-3 (AIDS) within 3 months after diagnosis is based on CD4 data or documentation of an AIDS-defining condition. This information is reported to CDC by all 50 states, the District of Columbia, and 6 US dependent areas. Differences between current and previous data estimates may be due to the availability of additional information, more complete data for previous years, the inclusion of additional years of data, or refinements in data adjustments and modeling.

Target Setting: The baseline year was established as 2010 by DHAP. The updated 2010 estimate reported in 2013 (25.2%) was used as the baseline. The revised 2015 goal (18.9%) reflects a 25% overall decrease from the baseline. Annual targets assume an accelerating rate of change over time and were based on the following assumptions for the percentage of total change that was expected in a given year: 2011 (5% of total change); 2012 (15% of total change); 2013 (20% of total change); 2014 (30% of total change); 2015 (30% of total change). Based on these assumptions, and the updated 2010 estimate, the current annual targets are: 2011 (24.9%); 2012 (23.9%); 2013 (22.7%); 2014 (20.8%).

References:

CDC. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas—2013. *HIV Surveillance Supplemental Report 2015;20(2)*. http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillancereport_vol20_no2.pdf. Published July 2015. Accessed October 2, 2015.

Reduce Perinatal HIV Transmission

Objective: By 2015, reduce by 25% the perinatal HIV transmission rate

Indicator: Number of perinatally acquired pediatric HIV cases per 100,000 live births

Numerator: Estimated number of infants with diagnosed perinatally acquired HIV infection who were born in the calendar year

Denominator: Estimated number of live births in the United States in the calendar year

Data Source: National HIV Surveillance System (NHSS) (numerator); National Vital Statistics System (denominator)

Indicator Notes: The perinatal HIV transmission rate is estimated using data about mothers and infants with a diagnosis of HIV infection, regardless of their stage of disease at diagnosis. The data are from the 50 states and the District of Columbia. They are statistically adjusted to account for delays between birth and diagnosis date, as well as between diagnosis and reporting of HIV infection. This does not include adjustments for incomplete reporting. These data are for black/African American, Hispanic/Latino, and white mothers and infants. Live birth data reflect the race/ethnicity of the mother. Differences between current and previous estimates may be due to the availability of additional information, more complete data for previous years, the inclusion of additional years of data, or refinements in data adjustments and modeling.

Target Setting: The baseline year was established as 2008 by DHAP. The updated 2008 estimate reported in 2015 (6.4 perinatal transmissions per 100,000 live births) was used as the baseline. The revised 2015 goal (4.8) reflects a 25% overall decrease from the baseline. Annual targets assume an accelerating rate of change over time and were based on the following assumptions for the percentage of total change in a given year: 2011 (5% of total change); 2012 (15% of total change); 2013 (20% of total change); 2014 (30% of total change); 2015 (30% of total change). Based on these assumptions, and the updated 2008 baseline estimate, the current annual targets are: 2011 (6.3); 2012 (6.1); 2013 (5.8); 2014 (5.3).

References:

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² The 6 US dependent areas are American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

Reduce Sexual Risk Behavior among MSM

Objective: By 2015, reduce by 25% the percentage of gay, bisexual and other men who have sex with men (MSM) who report condomless anal intercourse with a male sex partner of discordant or unknown HIV status during their last sexual encounter

Indicator: Percentage of MSM who reported condomless anal intercourse with a male sex partner of discordant or unknown HIV status during their last sexual encounter

Numerator: Number of MSM who reported condomless anal intercourse (defined as not using a condom or not using a condom the whole time during receptive or insertive anal sex) with a male partner of discordant or unknown HIV status during their last sexual encounter

Denominator: Number of male, eligible participants in the CDC's National HIV Behavioral Surveillance with complete, valid interview data who reported having sex with another man in the past 12 months

Data Source: National HIV Behavioral Surveillance (NHBS). NHBS MSM Cycle 2—conducted in 21 US cities from June to December 2008. NHBS MSM Cycle 3—conducted in 20 US cities from July to December 2011. NHBS MSM Cycle 4—conducted in 20 US cities from July to December 2014.

Indicator Notes: Data are collected in cities with a high burden of AIDS in venues frequented by gay, bisexual, and other MSM. To be eligible, respondents had to be male, 18 years of age or older, live in the local area, be able to complete the interview in English or Spanish, and report having ever had sex with another man. Analyses were limited to participants who had sex with a man in the past 12 months and complete, valid interview data. Condomless sex with an HIV-discordant partner at last sex is a composite measure based on self-reported HIV status of the participant (positive, negative, or unknown), the participant's knowledge of the HIV status of his most recent male sex partner (positive, negative, or unknown), and whether the participant reported engaging in anal sex without a condom during his most recent sexual encounter. A partner was considered to be of discordant HIV status if the participant reported that one member of the partnership was known to be HIV-positive and the other was known to be HIV-negative, or if he did not know the HIV status of at least one member of the partnership (participant or partner). Importantly, this indicator does not measure the use of other risk reduction strategies, including pre-exposure prophylaxis (PrEP) or viral suppression among HIV-positive partners.

Target Setting: The baseline year was established as 2008 by DHAP. The 2008 result (13.7%) was used as the baseline. The 2015 goal (10.3%) reflects a 25% overall decrease from the baseline. Annual targets for 2011 and 2014 (the years during the DHAP Strategic Plan for 2011–2015 in which NHBS data are collected for MSM) assume an accelerating rate of change over time and are based on the formula used to set annual targets for other indicators. Based on these assumptions, it was anticipated that 5% of the total change expected by the end of 2015 would be seen in the 2011 data and that 70% of the overall change would be seen in the 2014 data. Based on these assumptions, the current annual targets are 13.5% for 2011 and 11.3% for 2014.

References:

NHBS Data Request—September 14, 2015

CDC. HIV Risk, Prevention, and Testing Behaviors—National HIV Behavioral Surveillance System: Men Who have Sex with Men, 20 U.S. Cities, 2011. *HIV Surveillance Special Report*. http://www.cdc.gov/hiv/pdf/hssr_mmp_2011-pdf04.pdf. Published September 2014. Accessed October 2, 2015.

CDC. HIV risk, prevention, and testing behaviors among men who have sex with men—National HIV Behavioral Surveillance System, 21 U.S. cities, United States, 2008. *MMWR Surveillance Summary*. 2011;60.

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Reduce Sexual or Injection Risk Behavior among Persons Who Inject Drugs

Objective: By 2015, reduce by 25% the percentage of persons who inject drugs who report condomless sexual intercourse or risky drug injection behavior during the past 12 months

Indicator: Percentage of persons who inject drugs who reported condomless sexual intercourse or risky drug injection behavior in the past 12 months

Numerator: Number of eligible male and female persons who inject drugs who reported condomless sexual intercourse (defined as vaginal or anal sex without a condom with a partner of the opposite sex regardless of HIV status) or risky drug injection behavior (defined here as using a syringe that had been used by someone else) in the past 12 months

Denominator: Number of eligible male and female participants in the CDC's National HIV Behavioral Surveillance with complete, valid interview data who reported injecting drugs in the past 12 months and who did not report a previous HIV-positive test result

Data Source: National HIV Behavioral Surveillance (NHBS). NHBS Injection Drug Use (IDU) Cycle 1—conducted in 23 US cities from May 2005 to February 2006. NHBS IDU Cycle 2—conducted in 21 US cities from June to December 2009. NHBS IDU Cycle 3—conducted in 20 US cities from June to December 2012.

Indicator Notes: Data are collected in cities with a high burden of AIDS. Data are collected using respondent driven sampling (RDS), a method in which potential respondents are recruited by their peers. Males and females were eligible to participate if they were 18 years of age or older, lived in the local area, could complete the interview in English or Spanish, and reported injecting drugs in the past 12 months. Analyses were limited to participants with complete, valid data who did not report a previous HIV-positive test result. Condomless sexual intercourse was defined as vaginal or anal sex without a condom with a partner of the opposite sex, regardless of HIV status, during the past 12 months. Risky drug injection behavior was defined for this indicator as using a syringe that had been used by someone else. Indicator analysis was conducted using RDSAT to adjust for RDS. Importantly, this indicator does not measure the use of other risk reduction strategies, including pre-exposure prophylaxis (PrEP) or viral suppression among HIV-positive partners.

Target Setting: The baseline year was established as 2006 by DHAP. At the time the 2015 goal was established, this was the most recent year of data available prior to implementation of the DHAP Strategic Plan for 2011-2015. The 2006 estimate of 73.1% was used as the baseline. The 2015 goal (54.8%) reflects a 25% overall decrease from the baseline. The annual target for 2012 (the year during the DHAP Strategic Plan for 2011-2015 for which NHBS data are collected for IDUs) assumes an accelerating rate of change over time and is based on the formula used to set annual targets for other indicators. It was anticipated that 20% of the total expected change would be seen in the 2012 data. Based on this assumption, the annual target for 2012 is 69.4%.

References:

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CDC. HIV infection and HIV-associated behaviors among injecting drug users—20 cities, United States, 2009. *MMWR Morb Mortal Wkly Rep* 2012;61:133–8.

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Increase Linkage to HIV Medical Care

Objective: By 2015, increase to 85% the percentage of persons with HIV who are linked to HIV medical care within 3 months after diagnosis

Indicator: Percentage of HIV-diagnosed persons who are linked to HIV medical care as evidenced by having had a CD4 count or HIV viral load measure within 3 months after diagnosis

Numerator: Estimated number of persons aged 13 years and older with HIV diagnosed in the calendar year with a

CD4 count or HIV viral load measure within 3 months after diagnosis in jurisdictions that reported all CD4 and HIV viral load test results to CDC

Denominator: Estimated number of persons aged 13 years and older with HIV diagnosed in the calendar year (regardless of stage of disease at diagnosis) in jurisdictions that reported all CD4 and HIV viral load test results to CDC

Data Source: National HIV Surveillance System (NHSS)

Indicator Notes: Linkage to HIV medical care was based on data for persons with HIV infection diagnosed in the jurisdictions that reported all CD4 and HIV viral load test results to CDC. This included, in 2009, 13 jurisdictions—California (San Francisco only); Delaware; Indiana; Iowa; Kentucky; Missouri; Nebraska; New York (excluding New York City); North Dakota; South Carolina; West Virginia; Wyoming; and the District of Columbia; in 2010, 14 jurisdictions—all reporting in 2009 (except Kentucky) plus Illinois and Minnesota; in 2011, 19 jurisdictions—all reporting in 2010 plus Georgia, Hawaii, Louisiana, Michigan, New Hampshire, New York (including New York City), and California (including only San Francisco and Los Angeles County); in 2012, 18 jurisdictions—California, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maryland, Michigan, Missouri, New Hampshire, New York, North Dakota, South Carolina, Texas, Utah, West Virginia, and Wyoming; and in 2013, 28 jurisdictions—Alabama, Alaska, Arkansas, California, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Michigan, Missouri, Nebraska, New Hampshire, New York (including New York City), North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.

These data represent the best national estimate of linkage to care that is currently available. The representativeness of these data will improve over time as the number of jurisdictions reporting complete CD4 and HIV viral load data to CDC increases. People were considered linked to HIV medical care if laboratory data were reported showing that they had at least 1 CD4 or viral load test performed within 3 months after initial HIV diagnosis. Results for this indicator can be affected by changes in linkage to care, the number of areas reporting data, and completeness of laboratory reporting.

Target Setting: The National HIV/AIDS Strategy released in 2010 established the baseline at 65.0% for the year 2006. It also set the 2015 goal at 85.0%. This baseline and goal were adopted for the DHAP Strategic Plan for 2011–2015. Annual targets assume an accelerating rate of change over time and were based on the following assumptions for the percentage of total change that was expected to be achieved in a given year: 2011 (5% of total change); 2012 (15% of total change); 2013 (20% of total change); 2014 (30% of total change); 2015 (30% of total change). Based on these assumptions, the current annual targets are: 2011 (66.0%); 2012 (69.0%); 2013 (73.0%); 2014 (79.0%).

References:

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Increase Viral Suppression among Persons in HIV Medical Care

Objective: By 2015, increase by 10% the percentage of persons in HIV medical care with a suppressed viral load

Indicator: Percentage of adults in HIV medical care whose most recent HIV viral load test in the past 12 months showed that HIV viral load was suppressed

Numerator: Estimated number of adults aged 18 years and older in HIV medical care whose most recent viral load test in the past 12 months showed that HIV viral load was suppressed (defined as undetectable or fewer than 200 copies of HIV per milliliter of plasma)

Denominator: Estimated number of adults aged 18 years and older in HIV medical care in the United States and Puerto Rico in the first four months of the calendar year

Data Source: Medical Monitoring Project (MMP)

Indicator Notes: Data from MMP are based on a three-stage sampling approach that is designed to produce nationally representative information about adults receiving HIV medical care in the United States and Puerto Rico. Data are collected for samples of patients at outpatient HIV medical care facilities. Since 2009, 23 jurisdictions have been funded to participate in MMP activities. These jurisdictions include 16 states (California, Delaware, Florida, Georgia, Illinois, Indiana, Michigan, Mississippi, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Texas, Virginia, and Washington); 6 cities/counties (Chicago, Illinois; Houston, Texas; Los Angeles County, California; New York City, New York; Philadelphia, Pennsylvania; and San Francisco, California); and Puerto Rico. To be included, patients must be at least 18 years old, diagnosed with HIV, and have received HIV medical care at least once from January to April of the calendar year. Trained staff collect data through face-to-face interviews and medical record abstraction. These data are weighted to produce national estimates.

The data used for this indicator are based on medical records. Viral suppression is defined as having a most recent HIV viral load test result in the past 12 months that was undetectable or fewer than 200 copies/mL of plasma.

Target Setting: The baseline year was established as 2009 in the DHAP Strategic Plan for 2011-2015. The 2009 estimate (71.6%) was used as the baseline. The 2015 goal (78.8%) reflects a 10% overall increase from the baseline. Annual targets assume an accelerating rate of change over time, and were based on the following assumptions for the percentage of total change that was expected to be achieved in a given year: 2011 (5% of total change); 2012 (15% of total change); 2013 (20% of total change); 2014 (30% of total change); 2015 (30% of total change). Based on these assumptions, the current annual targets are: 2011 (72.0%); 2012 (73.0%); 2013 (74.5%); 2014 (76.6%).

References:

MMP Data Request—September 4, 2015

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Reduce Sexual Risk Behavior among Persons in HIV Medical Care

Objective: By 2015, reduce by 33% the percentage of persons in HIV medical care who report condomless anal or vaginal intercourse during the past 12 months with a partner of discordant or unknown HIV status

Indicator: Percentage of adults in HIV medical care who report condomless anal or vaginal intercourse in the past 12 months with a partner of discordant or unknown HIV status

Numerator: Estimated number of adults aged 18 years and older in HIV medical care who report condomless anal or vaginal intercourse in the last 12 months with a partner of discordant or unknown HIV status

Denominator: Estimated number of adults aged 18 years and older in HIV medical care in the first four months of the calendar year in the United States and Puerto Rico

Data Source: Medical Monitoring Project (MMP)

Indicator Notes: Data from MMP are based on a three-stage-sampling approach that is designed to produce nationally representative information about adults receiving HIV medical care in the United States and Puerto Rico. Data are collected for samples of patients at outpatient HIV medical care facilities. Since 2009, 23 jurisdictions have been funded to participate in MMP activities. These jurisdictions include 16 states (California, Delaware, Florida, Georgia, Illinois, Indiana, Michigan, Mississippi, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Texas, Virginia, and Washington); 6 cities/counties (Chicago, Illinois; Houston, Texas; Los Angeles County, California; New York City, New York; Philadelphia, Pennsylvania; and San Francisco, California); and Puerto Rico. To be included, patients must be at least 18 years old, diagnosed with HIV, and have received HIV medical care at least once from January to April of the calendar year. Trained staff collect data through face-to-face interviews and medical record abstraction. These data are weighted to produce national estimates.

This indicator is based on self-reported data from the face-to-face interviews. A discordant partner was a sex partner that the interview participant reported as being HIV negative. Partners of unknown HIV status include those who did not know their HIV status or did not disclose their status to the interview participant. This indicator measures condomless sex (insertive anal sex, receptive anal sex or vaginal sex without a condom) and does not take HIV treatment, viral load, partners' use of PrEP or other factors that affect HIV transmission into account.

Target Setting: The baseline year was established as 2009 in the DHAP Strategic Plan for 2011-2015. The 2009 estimate (12.9%) was used as the baseline. The 2015 goal (8.6%) reflects a 33% overall decrease from the baseline. Annual targets for 2011 through 2014 assumed an accelerated rate of change over time and were based on the following assumptions for the percentage of total change that was expected to be achieved in a given year: 2011 (5% of total change); 2012 (15% of total change); 2013 (20% of total change); 2014 (30% of total change); 2015 (30% of total change). Based on these assumptions, the current annual targets are: 2011 (12.7%); 2012 (12.1%); 2013 (11.2%); 2014 (9.9%).

References:

MMP Data Request—September 4, 2015

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Reduce HIV-Related Disparities and Health Inequities: Linkage to HIV Medical Care

Objective: By 2015, increase to 85% or greater for all race/ethnicity groups the percentage of persons diagnosed with HIV who are linked to HIV medical care within 3 months after diagnosis

Indicator: Percentage of blacks/African Americans, Hispanics/Latinos, whites, and persons of other races/ethnicities with HIV who are linked to HIV medical care as evidenced by having had a CD4 count or HIV viral load measure within 3 months after diagnosis

Numerator: Estimated number of blacks/African Americans, Hispanics/Latinos, whites, and persons of other races/ethnicities aged 13 years and older with HIV diagnosed in the calendar year and who have been linked to HIV medical care (as evidenced by having had a CD4 count or viral load measure within 3 months after diagnosis) in jurisdictions that reported all CD4 and viral load test results to CDC

Denominator: Estimated number of blacks/African Americans, Hispanics/Latinos, whites, and persons of other races/ethnicities aged 13 years and older with HIV diagnosed in the calendar year (regardless of stage of disease at diagnosis) in jurisdictions that reported all CD4 and viral load test results to CDC

Data Source: National HIV Surveillance System (NHSS)

Indicator Notes: Linkage to HIV medical care was based on data for blacks/African Americans, Hispanics/Latinos, whites, and persons of other races/ethnicities with HIV infection diagnosed in the jurisdictions that reported all

CD4 and viral load test results to CDC. This included, in 2009, 13 jurisdictions—California (San Francisco only); Delaware; Indiana; Iowa; Kentucky; Missouri; Nebraska; New York (excluding New York City); North Dakota; South Carolina; West Virginia; Wyoming; and the District of Columbia; in 2010, 14 jurisdictions—all reporting in 2009 (except Kentucky) plus Illinois and Minnesota; in 2011, 19 jurisdictions—all reporting in 2010 plus Georgia, Hawaii, Louisiana, Michigan, New Hampshire, New York (including New York City), and California (including only San Francisco and Los Angeles County); in 2012, 18 jurisdictions—California, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maryland, Michigan, Missouri, New Hampshire, New York, North Dakota, South Carolina, Texas, Utah, West Virginia, and Wyoming; and in 2013, 28 jurisdictions—Alabama, Alaska, Arkansas, California, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Michigan, Missouri, Nebraska, New Hampshire, New York (including New York City), North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.

These data represent the best national estimates of linkage to HIV medical care that are currently available. People were considered linked to HIV medical care if laboratory data were reported showing that they had at least 1 CD4 or VL test performed within 3 months after initial HIV diagnosis. Results for this indicator can be affected by changes in linkage to care, the number of areas reporting data, and completeness of laboratory reporting.

Target Setting: The baseline year was established as 2010 by DHAP. The 2015 goal was set by DHAP before data were available at 75.0% or greater for all race/ethnicity groups. The 2015 goal has been re-set to 85% or greater in all race/ethnicity groups. This aligns with the 2015 goal established in the National HIV/AIDS Strategy released in 2010 and the DHAP Strategic Plan for 2011-2015 for the nation as a whole. Annual targets assume an accelerating rate of change over time and were based on the following assumptions for the percentage of total change that was expected to be achieved in a given year: 2011 (5% of total change); 2012 (15% of total change); 2013 (20% of total change); 2014 (30% of total change); 2015 (30% of total change). Based on these assumptions, the annual targets for blacks/African Americans are: 2011 (77.3%); 2012 (78.5%); 2013 (80.1%); 2014 (82.6%). The annual targets for Hispanics/Latinos are: 2011 (83.2%); 2012 (83.5%); 2013 (83.9%); 2014 (84.4%). The annual targets for whites are: 2011 (83.6%); 2012 (83.8%); 2013 (84.1%); 2014 (84.6%). The annual targets for persons of other races/ethnicities are: 2011 (79.3%); 2012 (80.2%); 2013 (81.4%); 2014 (83.2%).

References:

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Reduce HIV-Related Disparities and Health Inequities: Viral Suppression among Persons with Diagnosed HIV

Objective: By 2015, increase by at least 20% the percentage of men who have sex with men (MSM), blacks/African Americans, and Hispanics/Latinos with a suppressed viral load

Indicator: Percentage of HIV-diagnosed MSM, blacks/African Americans, or Hispanics/Latinos aged 18 years and older whose most recent HIV viral load test in the past 12 months showed that HIV was suppressed

Numerator: Estimated number of adult MSM, blacks/African Americans, or Hispanics/Latinos aged 18 years and older in HIV medical care whose most recent viral load test in the past 12 months showed that HIV was suppressed (defined as undetectable or fewer than 200 copies of HIV per milliliter of plasma)

Denominator: Estimated number of adult MSM, blacks/African Americans, or Hispanics/Latinos aged 18 years and older in the United States and Puerto Rico who were diagnosed with HIV prior to the start of the reporting year and were alive at the end of the reporting year

Data Source: Medical Monitoring Project (MMP); National HIV Surveillance System (NHSS)

Indicator Notes: This indicator measures viral suppression using MMP data on HIV viral suppression from adults receiving HIV medical care and NHSS data on all people living with an HIV diagnosis. MMP data were used to estimate the number of adult MSM, blacks/African Americans, and Hispanics/Latinos receiving HIV medical care in the United States and Puerto Rico who achieved viral suppression. These data are based on medical records of HIV-diagnosed persons who received HIV medical care at least once from January to April of the calendar year. HIV viral suppression was assessed using information about the most recent HIV viral load test. Suppressed HIV viral load was defined as a result that was undetectable or fewer than 200 copies/mL. NHSS data were used to estimate the number of MSM, blacks/African Americans, and Hispanics/Latinos who had been diagnosed with HIV in the United States or Puerto Rico and were alive at the end of the calendar year.

Target Setting: Data from 2009 were used by DHAP to establish the baseline. The baseline number for each group was: 41.5% for MSM; 34.1% for blacks/African Americans; and 35.4% for Hispanics/Latinos. The 2015 goals (49.8% for MSM; 40.9% for blacks/African Americans; 42.5% for Hispanics/Latinos) reflect the 20% increase that was called for in the National HIV/AIDS Strategy released in 2010 and the DHAP Strategic Plan for 2011-2015. Annual targets assume an accelerating rate of change over time, and were based on the following assumptions for the percentage of total change that was expected to be achieved in a given year: 2011 (5% of total change); 2012 (15% of total change); 2013 (20% of total change); 2014 (30% of total change); 2015 (30% of total change). Based on these assumptions, the annual targets for MSM with diagnosed HIV are: 2011 (41.9%); 2012 (43.2%); 2013 (44.8%); 2014 (47.3%). The annual targets for blacks/African Americans with diagnosed HIV are: 2011 (34.4%); 2012 (35.5%); 2013 (36.8%); 2014 (38.9%). The annual targets for Hispanics/Latinos with diagnosed HIV are: 2011 (35.8%); 2012 (36.8%); 2013 (38.2%); 2014 (40.4%).

References:

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