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Houston Area Comprehensive HIV Prevention and Care Services Plan 2017 - 2021

*Capturing the community's vision for an ideal system of
HIV prevention and care for the Houston Area*

HOUSTON EMA HIV CARE CONTINUUM

What is the Care Continuum?

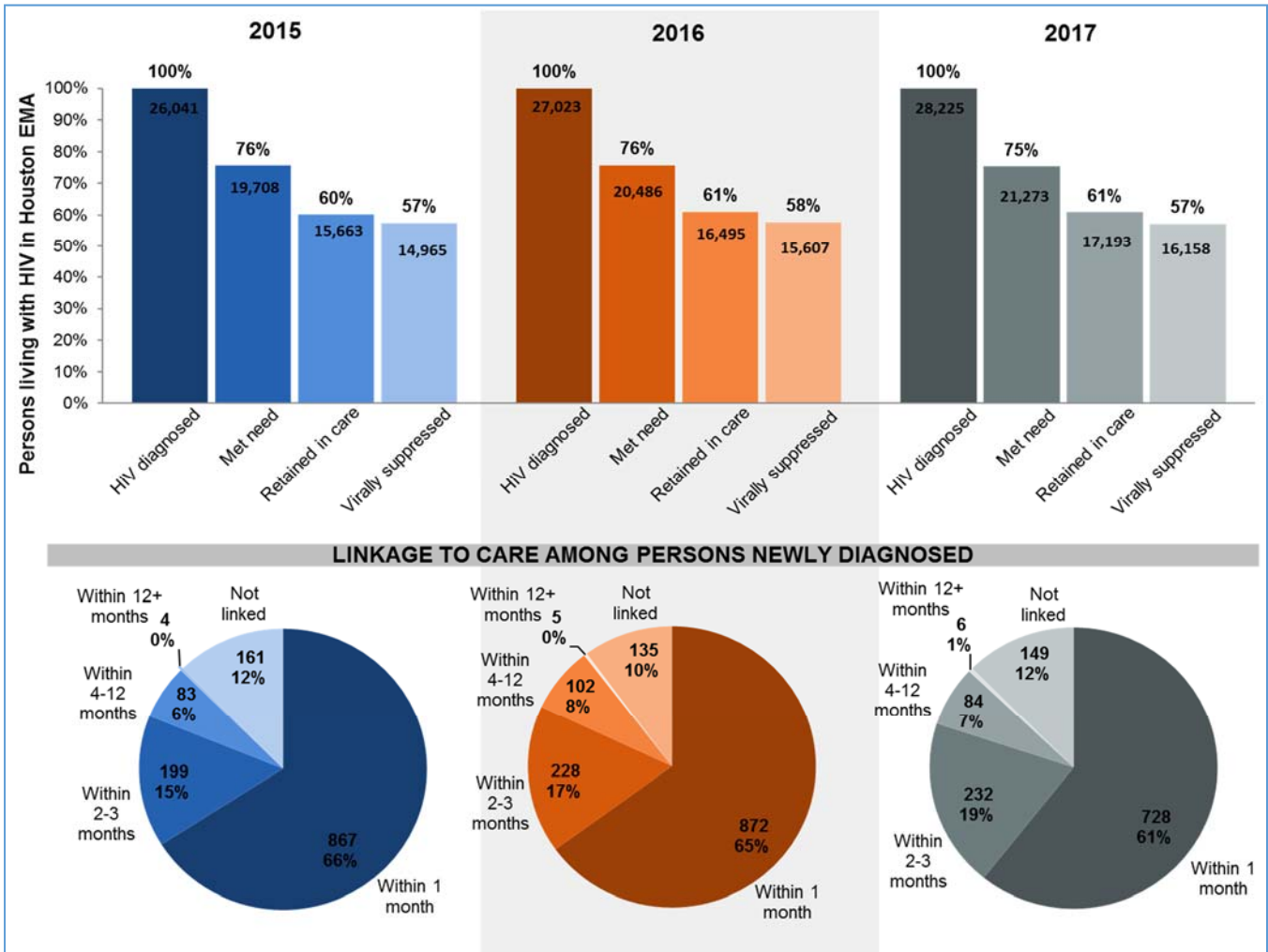
The HIV Care Continuum, previously known as a Treatment Cascade, was first released in 2012 by the Centers for Disease Control and Prevention (CDC). It represents the sequential stages of HIV care, from being diagnosed with HIV to suppressing the HIV virus through treatment. Ideally, the Care Continuum describes a seamless system of HIV prevention and care services, in which people living with HIV (PLWH) receive the full benefit of HIV treatment by being diagnosed, linked to care, retained in care, and taking HIV medications as prescribed to achieve viral suppression.

The Houston EMA Care Continuum (HCC)

The HCC is a diagnosis-based continuum. The HCC reflects the number of PLWH who have been diagnosed ("HIV diagnosed"); and among the diagnosed, the numbers and proportions of PLWH with records of engagement in HIV care ("Met need"), retention in care ("Retained in care"), and viral suppression ("Virally suppressed") within a calendar year. Although retention in care is a significant factor for PLWH to achieve viral suppression, 'Virally suppressed' also includes those PLWH in the Houston EMA whose most recent viral load test of the calendar year was <200 copies/mL but who did not have evidence of retention in care.

Linking newly diagnosed individuals into HIV medical care as quickly as possible following initial diagnosis is an essential step to improved health outcomes. In the HCC, initial linkage to HIV medical care ("Linkage to care") is presented separately as the proportion of *newly* diagnosed PLWH in the Houston EMA who were successfully linked to medical care within three months or within one year after diagnosis

Figure 1: Houston EMA HIV Care Continuum, 2015-2017



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2018

Measure	Description	Data source
HIV diagnosed	No. of persons living with HIV (PLWH) residing in Houston EMA through end of year (alive)	Texas eHARS data
Met need	No. (%) of PLWH in Houston EMA with met need (at least one: medical visit, ART prescription, or CD4/VL test) in year	Texas DSHS HIV Unmet Need Project (incl. eHARS, ELR, ARIES, ADAP, Medicaid, private payer data)
Linked to care (pie chart)	No. (%) of newly diagnosed PLWH in Houston EMA who were linked to medical care ("Met need") within N months of their HIV diagnosis	
Retained in care	No. (%) of PLWH in Houston EMA with at least 2 medical visits, ART prescriptions, or CD4/VL tests in year, at least 3 months apart	
Virally suppressed	No. (%) of PLWH in Houston EMA whose last viral load test of the year was ≤ 200 copies/mL	Texas ELRs, ARIES labs, ADAP labs

From 2015-2017, the total number of persons diagnosed with HIV increased each year and the percentage of those with met need, retention, and viral suppression remained relatively constant.

- The percentage of newly diagnosed PLWH linked to care within one month of diagnosis decreased by 5% from 2015 to 2017.

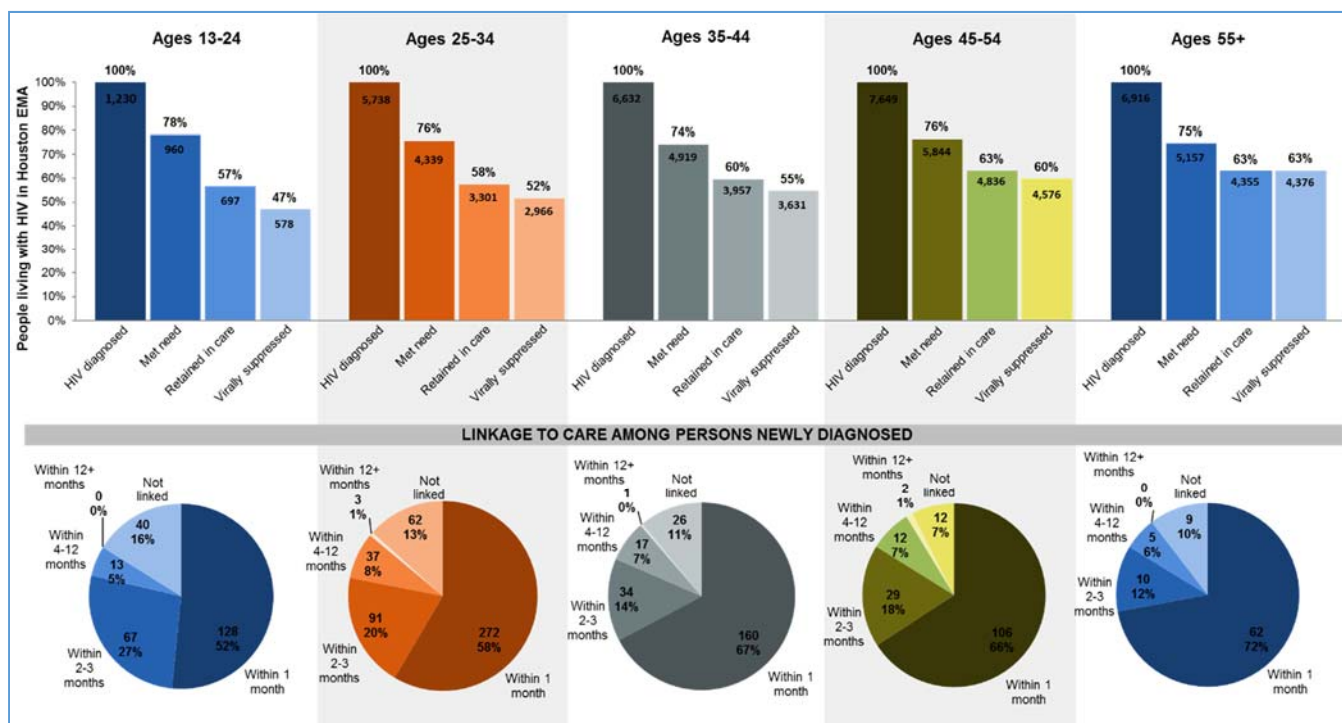
Disparities in Engagement among Key Populations

Multiple versions of the HCC have been created to illustrate engagement disparities and service gaps that key populations encounter in the Houston EMA.

It is important to note that available data used to construct each version of the Houston EMA HCC do not portray the need for activities to increase testing, linkage, retention, ART access, and viral suppression among many other at-risk key populations, such as those who are intersex, experiencing homelessness, or those recently released from incarceration.

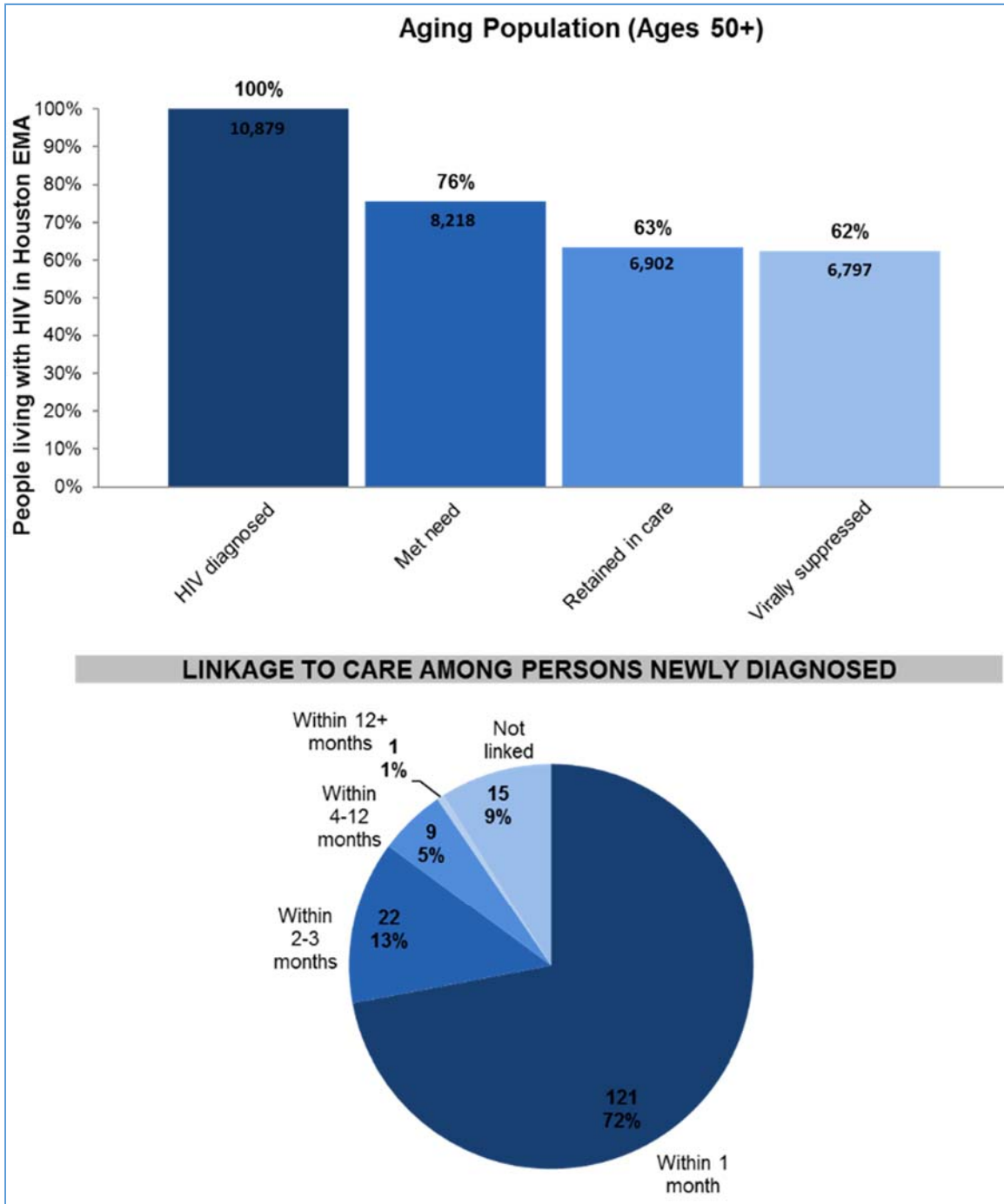
The Houston EMA Care Continuum, by Age

Figure 2: Houston EMA HIV Care Continuum by Age Group, 2017



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2018

Figure 3: Houston EMA HIV Care Continuum by Aging Population 50+, 2017



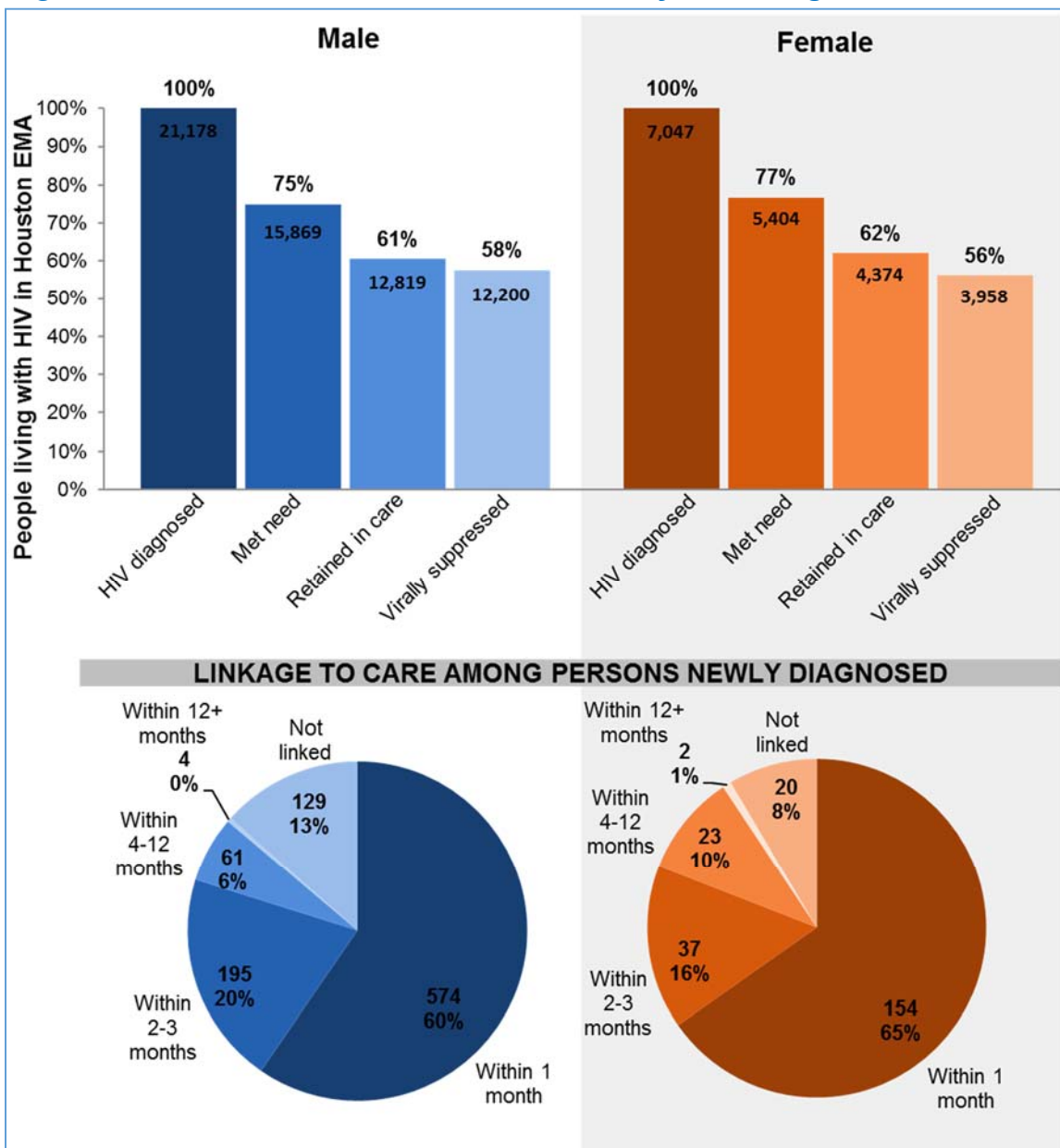
Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2018

- Younger adults had lower percentages of retention and viral suppression compared to older adults.
- Youth and young adults (13-24 years old) had the highest percentage of met need.

- Youth to middle age adults (13-34 years old) had the lowest proportion of newly diagnosed PLWH who were linked within three months of diagnosis when compared to the older adult age groups.

The Houston EMA Care Continuum, by Sex Assigned at Birth/Current Gender

Figure 4: Houston EMA HIV Care Continuum by Sex Assigned at Birth, 2017

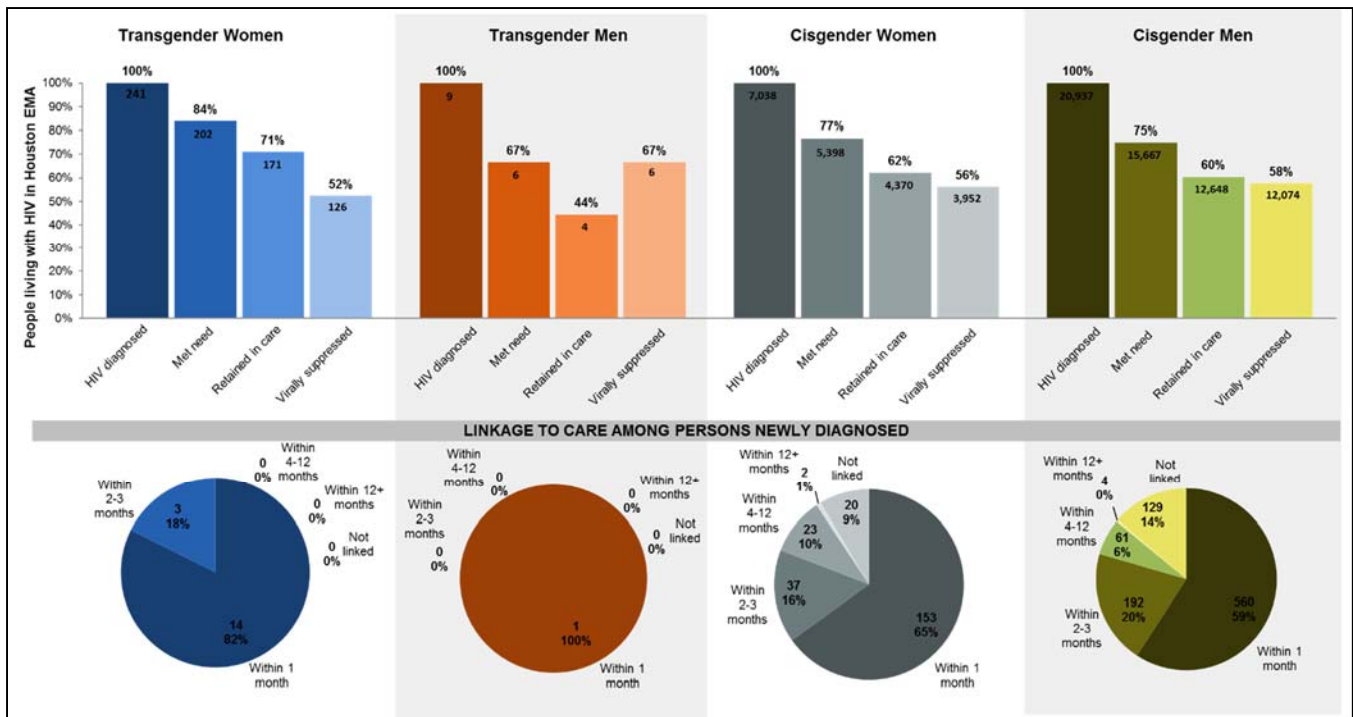


Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2018

- Females living with HIV in the Houston EMA in 2017 had a higher proportion of individuals with met need and retention in care than males living with HIV, although females had a slightly smaller proportion of viral suppression.

- The proportion of newly diagnosed female PLWH linked to care within the first month after diagnosis was 5% higher than males.

Figure 5: Houston EMA HIV Care Continuum by Current Gender, 2017

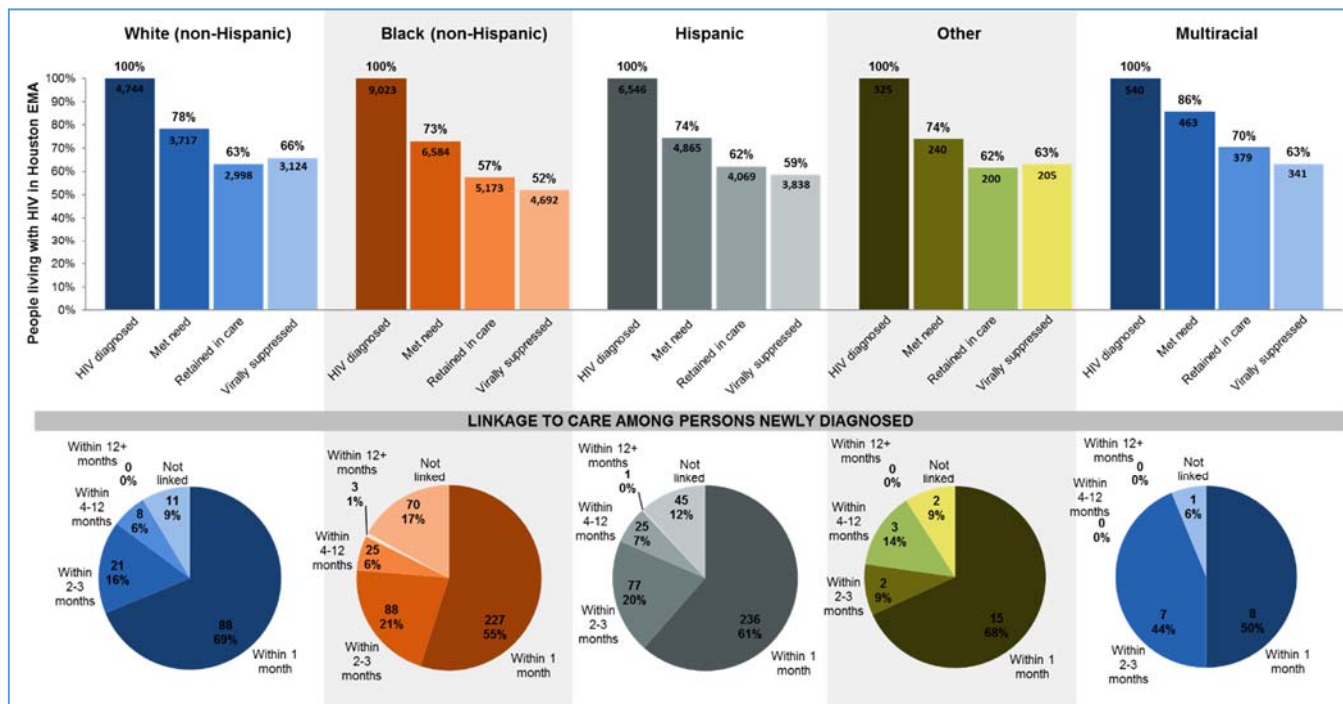


Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2018

- Transgender women living with HIV in the Houston EMA in 2017 had the highest proportion of individuals with met need and retention in care. However, they had the lowest proportion of viral suppression.
- Transgender men living with HIV in the Houston EMA in 2017 had the lowest proportion of individuals retained in care but had the highest viral suppression. Caution should be exercised in interpretation, however, due to the very small numbers of transgender men represented in this data.
- The proportion of newly diagnosed people linked to care within the first month after diagnosis was higher for transgender people compared to cisgender people. However, the transgender groups had few individuals and percentages can vary widely with small increases/decreases.

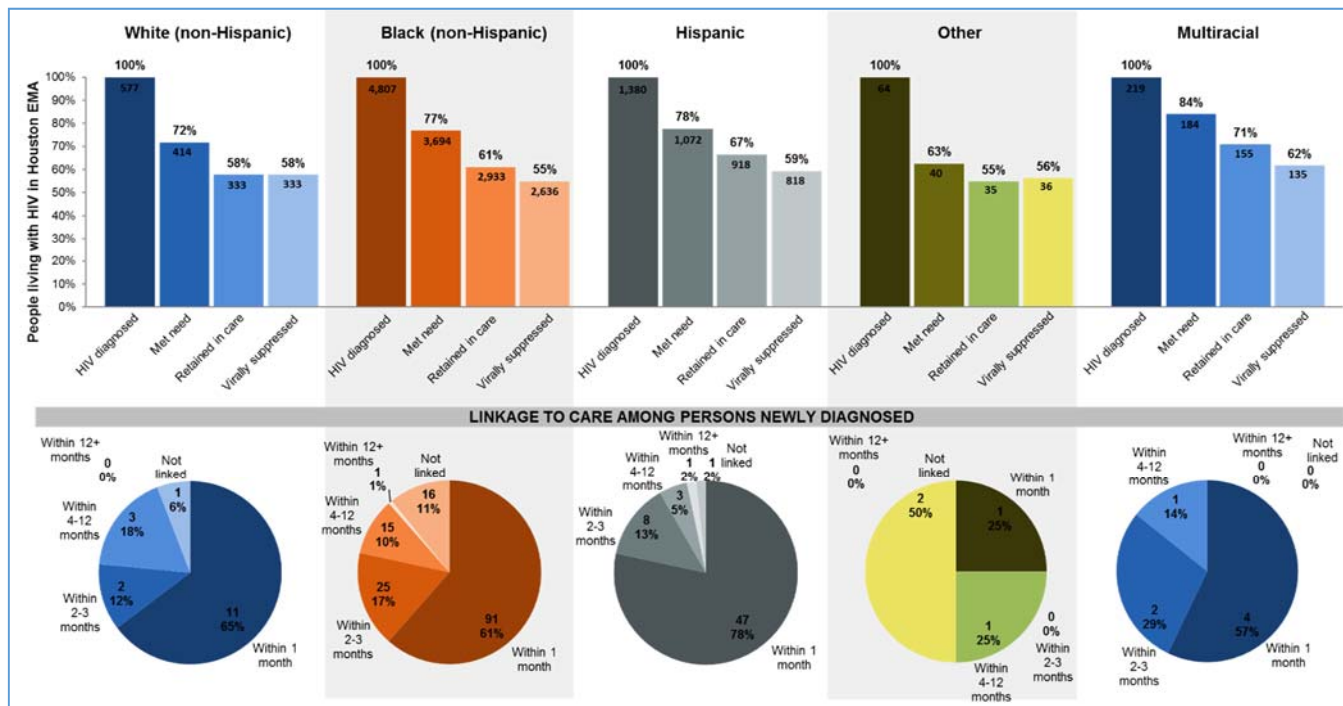
The Houston EMA Care Continuum, by Sex Assigned at Birth and Race/Ethnicity

Figure 6: Houston EMA HIV Care Continuum by Sex Assigned at Birth=Male and Race/Ethnicity, 2017



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2018

Figure 7: Houston EMA HIV Care Continuum by Sex Assigned at Birth=Female and Race/Ethnicity, 2017



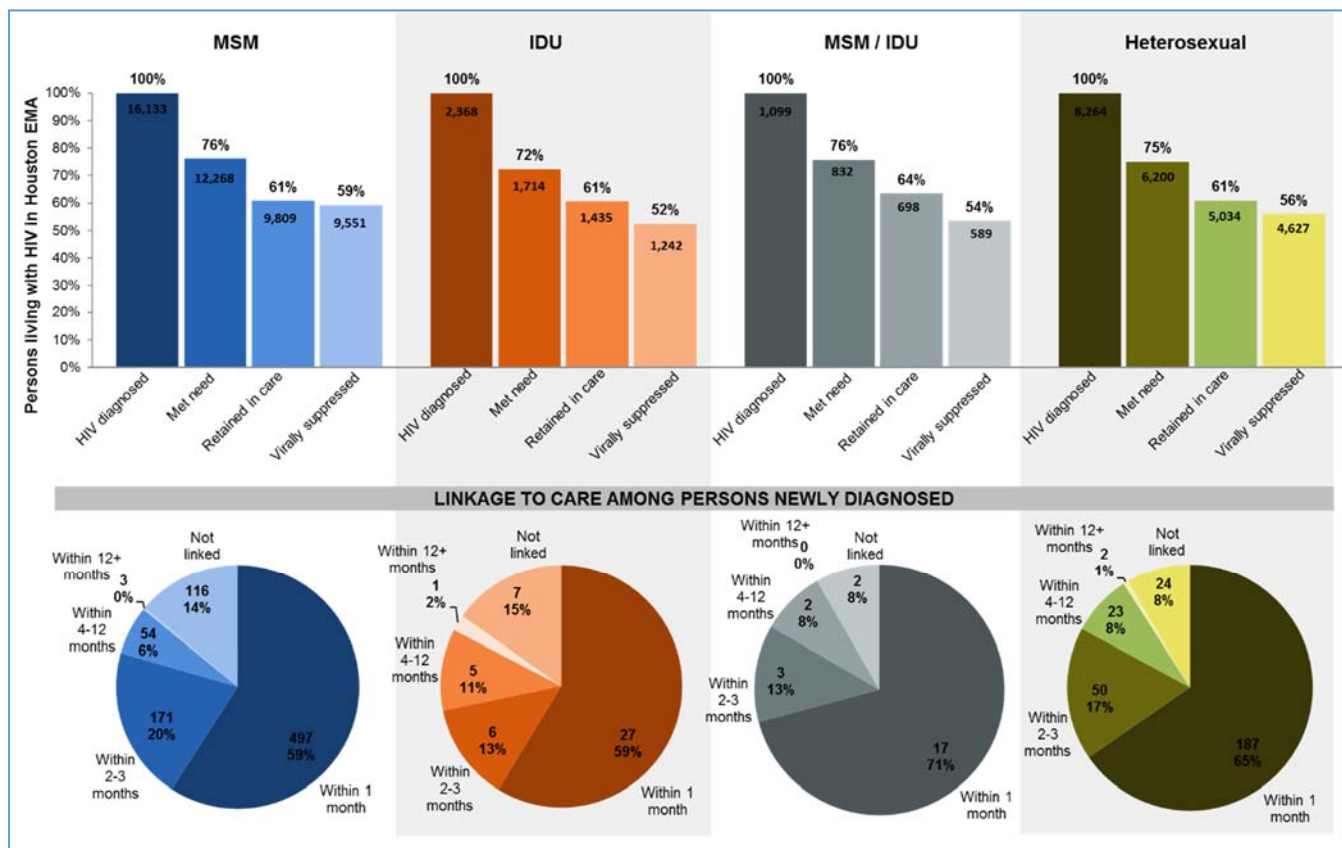
Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2018

- Compared to White and multiracial males, all other males living with HIV had lower proportions of met need, retention in care, and viral suppression in 2017.
- Among females, Other (non-Hispanic) PLWH had the lowest proportion of individuals with evidence of met need and retention in care while Black (non-Hispanic) PLWH had the lowest proportion of individuals with evidence of viral suppression.
- Among those newly diagnosed with HIV, Hispanic females and White (non-Hispanic) males had the highest proportion linked to care within 1 month of diagnosis.
- Overall, Other (non-Hispanic) females living with HIV had the lowest proportion of individuals with met need across all birth sex and race/ethnicity groups. However, this group had few individuals and percentages can vary widely with small increases/decreases. White (non-Hispanic) females living with HIV had the next lowest proportion of individuals with met need.
- Overall, Other (non-Hispanic) females living with HIV had the lowest proportion of individuals retained in care across all birth sex and race/ethnicity groups. However, this group had few individuals and percentages can vary widely with small increases/decreases. Black (non-Hispanic) males living with HIV had the next lowest proportion of individuals retained in care.
- Overall, Black (non-Hispanic) males living with HIV had the lowest proportion of individuals virally suppressed across all birth sex and race/ethnicity groups

The Houston EMA Care Continuum, by Transmission Risk Factor*

*Transmission risk factors that are associated with increased risk of HIV exposure and transmission include men who have sex with men (MSM), injection drug use (IDU), MSM who also practice IDU (MSM/IDU), and heterosexual exposure.

Figure 8: Houston EMA HIV Care Continuum by Transmission Risk, 2017



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2018

- Although MSM have higher numbers of PLWH than the other risk groups, the proportion of diagnosed MSM living with HIV with evidence of met need and retention in care is similar to those observed for other risk groups.
- MSM also have a higher proportion of diagnosed PLWH who are virally suppressed but a lower proportion of newly diagnosed PLWH who were successfully linked to care within one month of initial diagnosis.
- Overall, PLWH with IDU as a primary transmission risk factor exhibited the lowest proportions of individuals in each care continuum stage.

Questions about the Houston EMA HIV Care Continuum can be directed to: [Amber Harbolt](#), Health Planner in the Office of Support.

Houston HSDA

Houston HSDA Counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton

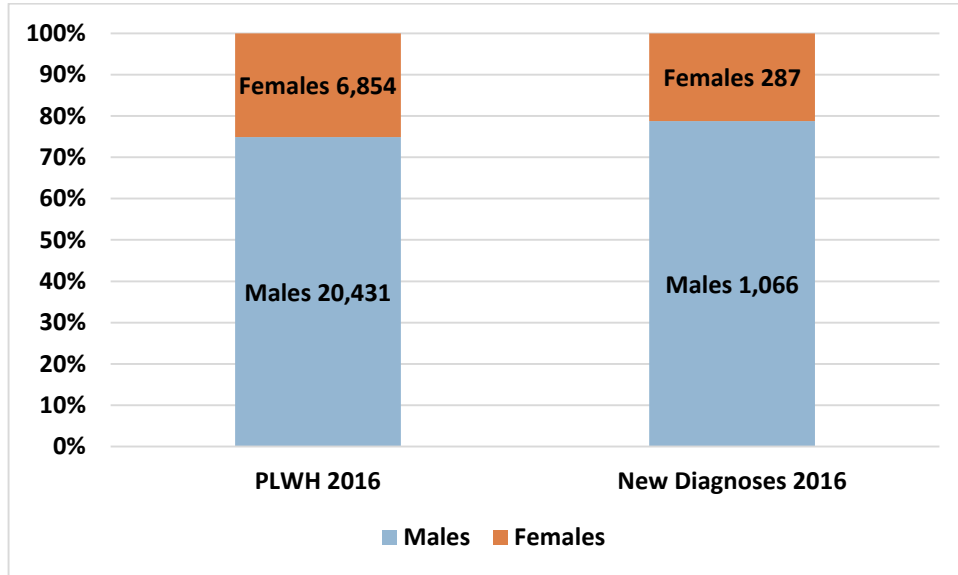
Epi Profile

In the Houston HSDA, the number of new diagnoses has remained flat and stable for the past several years.

There were **27,285 people living with HIV (PLWH)** in this area as of the end of 2016. This includes only people with diagnosed infections with a current address in this area. People with undiagnosed HIV are not included. In 2016, **1,353 people were newly diagnosed with HIV.**

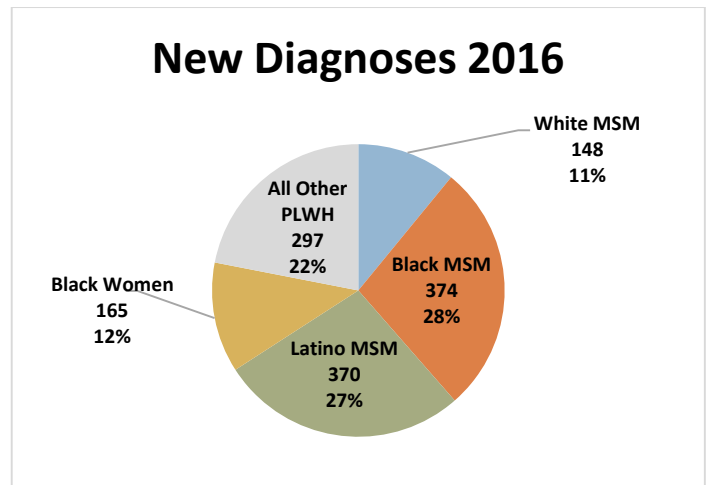
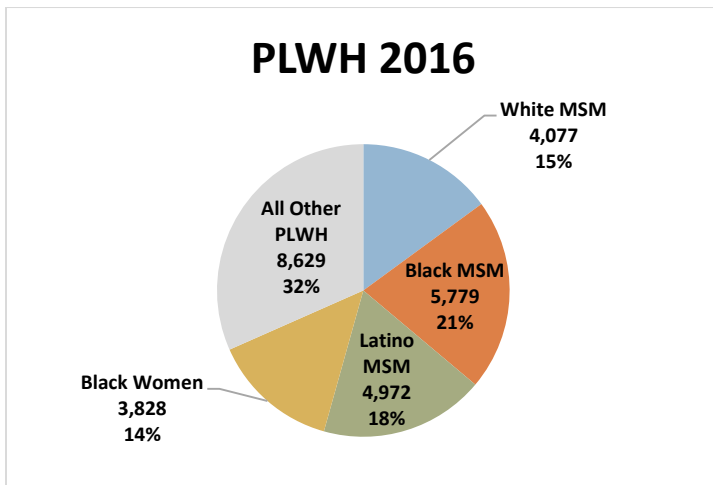
Gender

Men make up the majority of PLWH and the majority of new diagnoses.



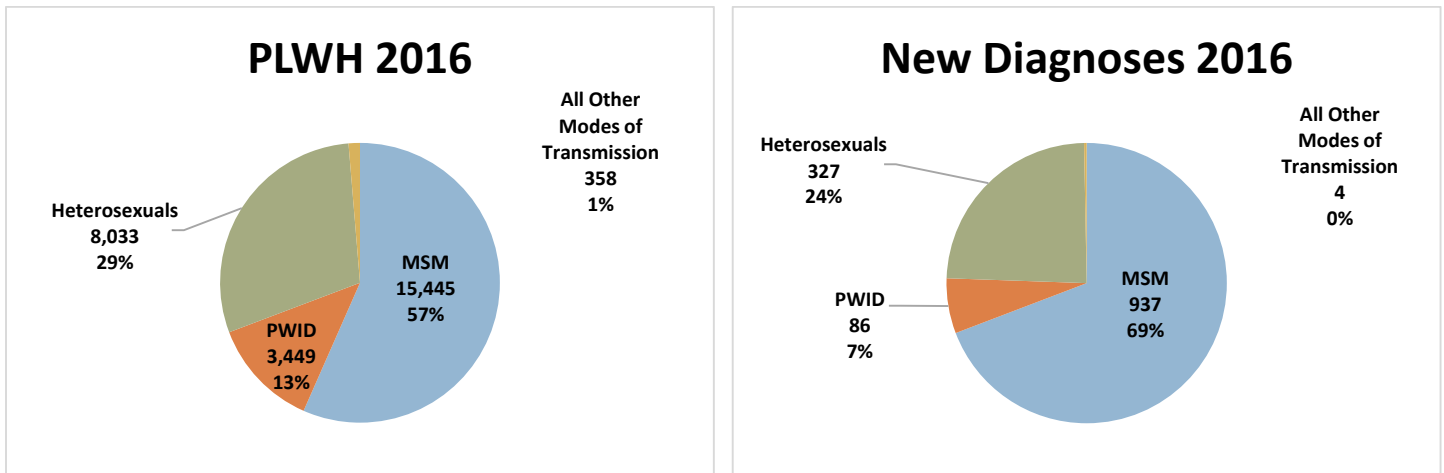
Priority Populations (68% of total PLWH, 78% of new diagnoses)

Priority populations make up the majority of PLWH and the majority of new diagnoses. Black MSM are the largest priority population among PLWH and among new diagnoses.



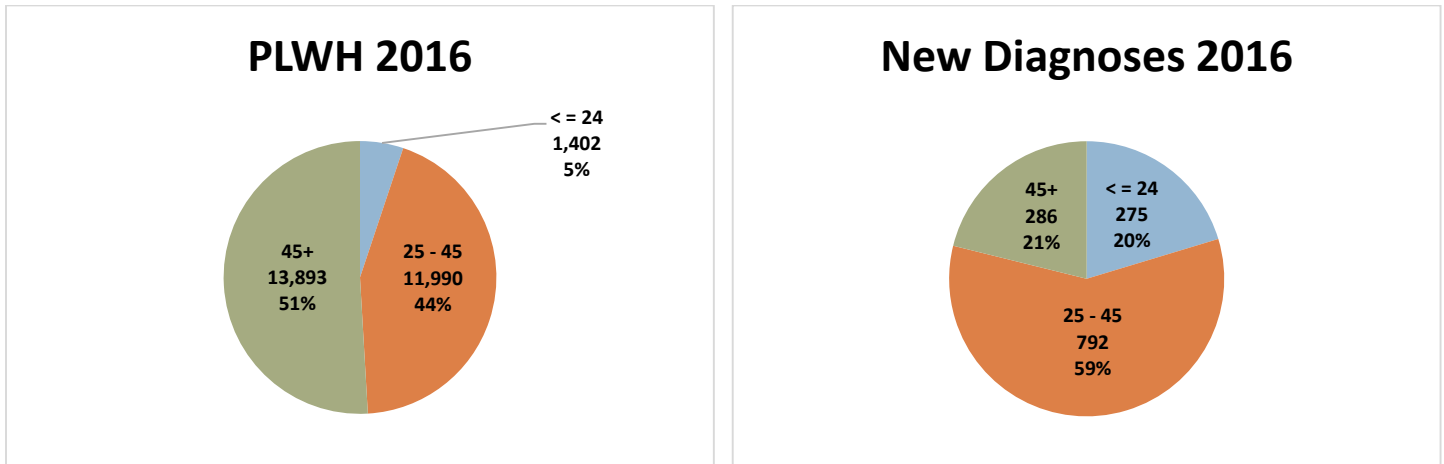
Mode of Exposure

MSM makes up the primary mode of exposure among PLWH and among new diagnoses.



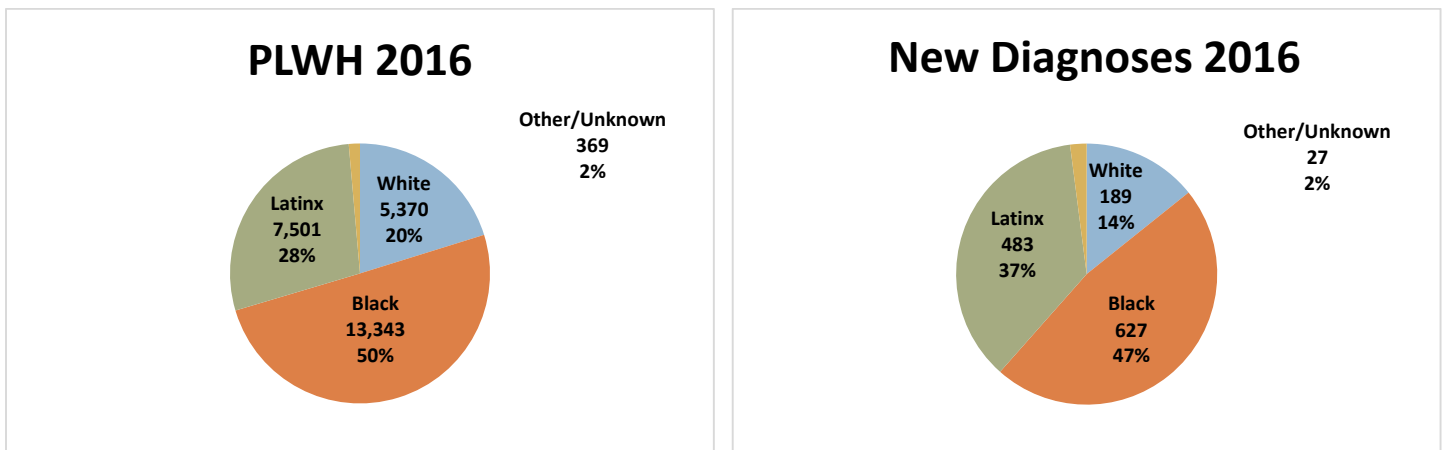
Age

The majority of PLWH are 45 and older; the majority of new diagnoses are among people 25-45.



Race/Ethnicity

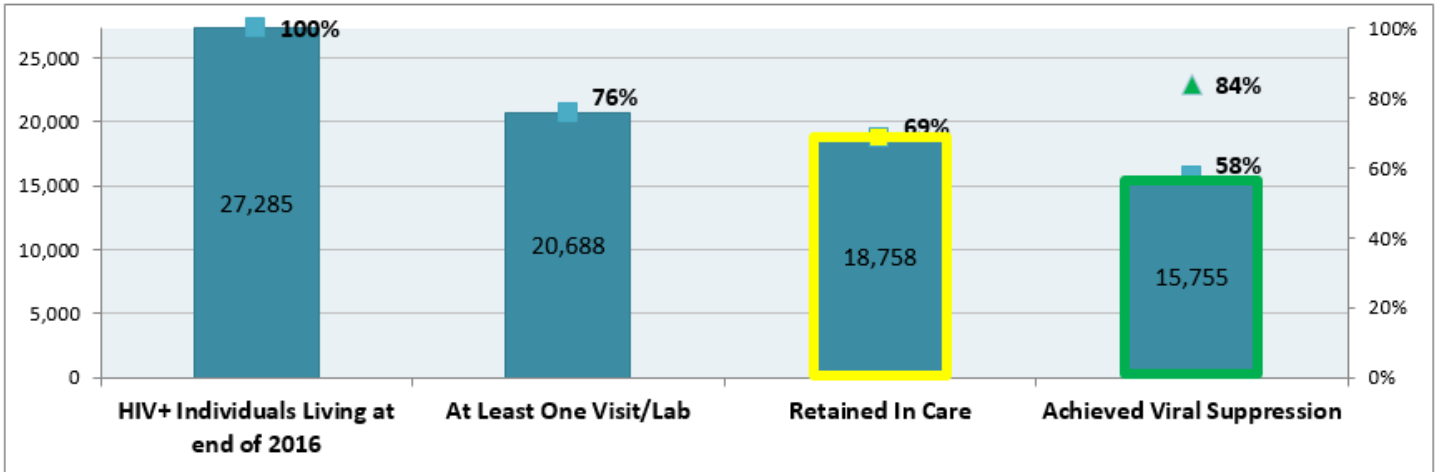
The majority of PLWH and the majority of new diagnoses are among Black individuals.



2016 Care Continuum

When people are able to achieve retention in care, they are able to achieve viral suppression. In the Houston HSDA, 58% of total PLWH have achieved viral suppression, and 84% of PLWH who are retained in care achieved viral suppression. Retention in care is a priority area.

Houston HSDA HIV Population Treatment Cascade, 2016



76% of PLWH had at least one episode of HIV care & treatment. This means roughly 8 out of 10 PLWH were in care.



69% of PLWH were retained in care (2 episodes of HIV care & treatment across the year). This means that roughly 7 out of 10 PLWH were retained in care



58% of PLWH were virally suppressed. This means that roughly 6 out of 10 PLWH were virally suppressed



Of those 7 out of 10 PLWH who were retained in care, 84%, or roughly 6 of those 7 PLWH, were virally suppressed.

2016 Continuum of Care, Parity Table

All communities who are retained in care are able to achieve viral suppression goals, except for people under the age of 35 and People Who Inject Drugs (PWID).

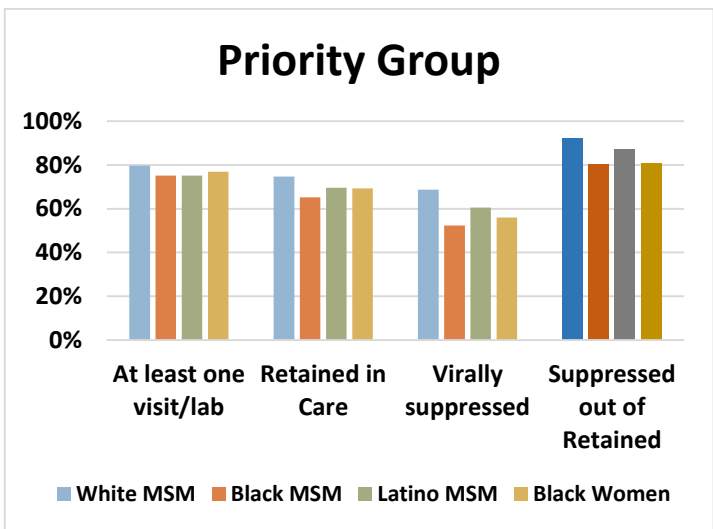
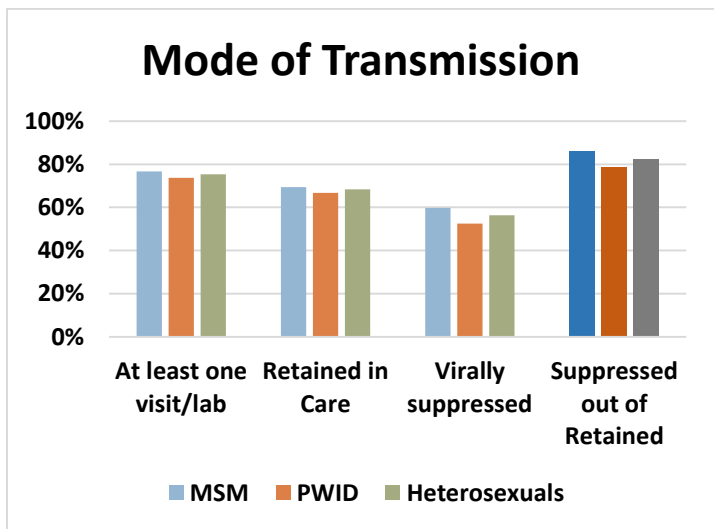
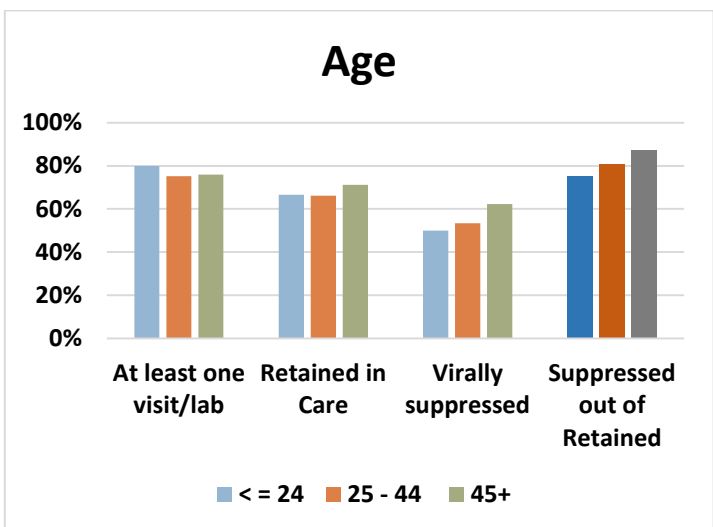
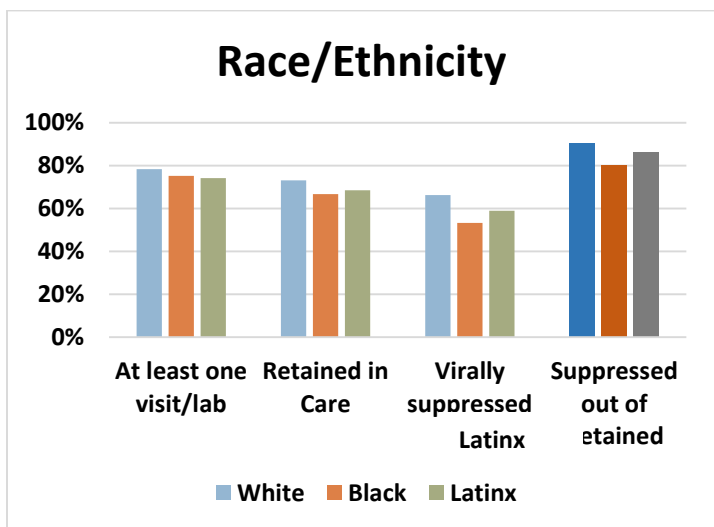
Communities with the fewest opportunities to achieve retention are people under the age of 45, People Who Inject Drugs (PWID), Heterosexuals, Men and Black PLWH, specifically Black MSM.

85% PLWH retained in HIV care and treatment

80% Of those retained are virally suppressed

	PLWH		At least one visit		Retained in Care		% retained if any care	Suppressed		% suppressed of those retained
	#	%	#	%	#	%	%	#	%	%
All PLWH	27,285	100%	20,688	76%	18,758	69%	91%	15,755	58%	84%
Female	6,854	25%	5,296	77%	4,792	70%	90%	3,887	57%	81%
Male	20,431	75%	15,392	75%	13,966	68%	91%	11,868	58%	85%
White	5,370	20%	4,206	78%	3,297	73%	78%	3,553	66%	90%
Black	13,343	49%	10,037	75%	8,896	67%	89%	7,106	53%	80%
Latinx	7,501	27%	5,562	74%	5,140	69%	92%	4,422	59%	86%
<=24	1,402	5%	1,121	80%	933	67%	83%	700	50%	75%
25 – 34	5,491	20%	4,176	76%	3,567	65%	85%	2,804	51%	79%
35 – 44	6,499	24%	4,836	74%	4,369	67%	90%	3,597	55%	82%
45+	13,893	51%	10,555	76%	9,889	71%	94%	8,654	62%	88%
MSM	15,445	57%	11,834	77%	10,724	69%	91%	9,236	60%	86%
PWID	3,449	13%	2,542	74%	2,301	67%	91%	1,811	53%	79%
Heterosexual	8,033	29%	6,052	75%	5,495	68%	91%	4,532	56%	82%
White MSM	4,077	15%	3,250	80%	3,045	75%	94%	2,802	69%	92%
Black MSM	5,779	21%	4,344	75%	3,771	65%	87%	3,028	52%	80%
Latino MSM	4,972	18%	3,735	75%	3,459	70%	93%	3,012	61%	87%
Black Women	3,828	14%	2,942	77%	2,654	69%	90%	2,143	56%	81%

2016 Continuum of Care, Parity Bar Charts



Targets

Among priority populations, the community with the greatest need for new opportunities to achieve retention are Black MSM.

85% PLWH retained in HIV care and treatment

80% Of those retained are virally suppressed

	PLWH		Retained in Care		85% retained goal	Gap	Suppressed	80% suppressed goal	Gap
	#	%	#	%	#	#	#	#	#
All PLWH	27,285	100%	18,758	69%	23,192	4,434	15,755	18,554	2,799
Female	6,854	25%	4,792	70%	5,826	1,034	3,887	4,661	774
Male	20,431	75%	13,966	68%	17,366	3,400	11,868	13,893	2,025
White	5,370	20%	3,297	73%	4,565	638	3,553	3,652	99
Black	13,343	49%	8,896	67%	11,342	2,446	7,106	9,074	1,968
Latinx	7,501	27%	5,140	69%	6,376	1,236	4,422	5,101	679
<=24	1,402	5%	933	67%	1,192	259	700	953	253
25 – 34	5,491	20%	3,567	65%	4,667	1,100	2,804	3,734	930
35 – 44	6,499	24%	4,369	67%	5,524	1,155	3,597	4,419	822
45+	13,893	51%	9,889	71%	11,809	1,920	8,654	9,447	793
MSM	15,445	57%	10,724	69%	13,128	2,404	9,236	10,502	1,266
PWID	3,449	13%	2,301	67%	2,932	631	1,811	2,346	535
Heterosexual	8,033	29%	5,495	68%	6,828	1,333	4,532	5,462	930
White MSM	4,077	15%	3,045	75%	3,465	420	2,802	2,772	-30
Black MSM	5,779	21%	3,771	65%	4,912	1,141	3,028	3,930	902
Latino MSM	4,972	18%	3,459	70%	4,226	767	3,012	3,381	369
Black Women	3,828	14%	2,654	69%	3,254	600	2,143	2,603	460

★ ROADMAP ★

TO ENDING THE HIV EPIDEMIC IN HOUSTON

~December 2016~



Excerpt for How to Best Meet the Needs
Full document available at www.endhivhouston.org

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ACCESS TO CARE

The vision of the access to care work group is to ensure all residents of the Houston Area receive proactive and timely access to comprehensive and non-discriminatory care to prevent new diagnoses, and for those living with HIV/AIDS to achieve and maintain viral suppression.

Recommendation 1: Enhance the health care system to better respond to the HIV/AIDS epidemic

The ability of the local health care system to appropriately respond to the HIV/AIDS epidemic is a crucial component to ending the epidemic in Houston. FQHCs, in particular, represent a front line for providing comprehensive and appropriate access to care for people living with HIV/AIDS. While we acknowledge the commitment of many medical providers to provide competent care, ending the epidemic will require a more coordinated and focused response.

Some specific actions include:

- Develop a more coordinated and standard level of HIV prevention services and referrals for treatment, so that patients receive the same type and quality of services no matter where care is accessed.
- Integrate a women-centered care model approach to increase access to sexual and reproductive health services. Women-centered care meets the unique needs of women living with HIV and provides care that is non-stigmatizing, holistic, integrated, and gender-sensitive.
- Train more medical providers on the Ryan White care system.
- Explore feasibility of implementing a pilot rapid test and treat model, in which treatment would start immediately upon receipt of a positive HIV test.
- Better equip medical providers and case managers with training on best practices, latest developments in care and treatment, and opportunities for continuing education credits.
- Increase use of METRO Q[®] Fare Cards, telemedicine, mobile units, and other solutions to transportation barriers.
- Develop performance measures to improve community viral load as a means to improve health outcomes and decrease HIV transmission.
- Integrate access to support services such as Women, Infants and Children (WIC), food stamps, Children's Health Insurance Program (CHIP), and health literacy resources in medical settings.

**Ending the epidemic
will require a more
coordinated and
focused response.**

Develop cultural trainings in partnership with members of the community that address the specific cultural and social norms of the community.

Recommendation 2: Improve cultural competency for better access to care

Lack of understanding of the social and cultural norms of the community is one of the most cited barriers to care. These issues include race, culture, ethnicity, religion, language, poverty, sexual orientation and gender identity. Issues related to the lack of cultural competency are more often experienced by members of the very communities most impacted by HIV. Medical providers must improve their cultural understanding of the communities they serve in order to put the “care” back in health care. Individuals will not seek services in facilities they do not feel are designed for them or where they receive insensitive treatment from staff.

Some specific actions include:

- Develop cultural trainings in partnership with members of the community that address the specific cultural and social norms of the community.
- Include training on interventions for trauma-informed care and gender-based violence. This type of care is a treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma that contribute to mental health issues including substance abuse, domestic violence, and child abuse.
- Establish measures to evaluate effectiveness of training.
- Revise employment applications to include questions regarding an applicant’s familiarity with the community being served. New hires with lack of experience working with certain communities should receive training prior to interacting with the community.

Recommendation 3: Increase access to mental health services and substance abuse treatment

Access to behavioral health and substance abuse treatment are two of the most critical unmet needs in the community. Individuals have difficulty staying in care and adhering to medication without access to mental health and substance abuse treatment. Comprehensive HIV/AIDS care must address the prevalence of these conditions.

Some specific actions include:

- Perform mental health assessments on newly diagnosed persons to determine readiness for treatment, the existence of an untreated mental health disorders, and need for substance abuse treatment.
- Increase the availability of mental health services and substance abuse treatment, including support groups and peer advocacy programs.
- Implement trauma-informed care in health care settings to respond to depression and post-traumatic stress disorders.

Increase the availability of mental health services and substance abuse treatment.



Recommendation 4: Improve health outcomes for people living with HIV/AIDS with co-morbidities

Because of recent scientific advances, people living with HIV/AIDS, who have access to antiretroviral therapy, are living long and healthy lives. HIV/AIDS is now treated as a manageable chronic illness and is no longer considered a death sentence. However, these individuals are developing other serious health conditions that may cause more complications than the virus. Some of these other conditions include Hepatitis C, hypertension, diabetes, and certain types of cancer. When coupled with an HIV diagnosis, these additional conditions are known as co-morbidities. HIV treatment must address the impact of co-morbidities on treatment of HIV/AIDS.

Some specific actions include:

- Utilize a multi-disciplinary approach to ensure that treatment for HIV/AIDS is integrated with treatment for other health conditions.
- Develop treatment literacy programs and medication adherence support programs for people living with HIV/AIDS to address co-morbidities.

Recommendation 5: Develop and publicize complete and accurate data for transgender people and those recently released from incarceration

There is insufficient data to accurately measure the prevalence and incidence of HIV among transgender individuals. In addition, there appears to be a lack of data on those recently released from incarceration. We need to develop data collection protocols to improve our ability to define the impact of the epidemic on these communities.

Recommendation 6: Streamline the Ryan White eligibility process for special circumstances

The Ryan White program is an important mechanism for delivering services to individuals living with HIV/AIDS. In order to increase access to this program, we must remove barriers to enrollment for qualified individuals experiencing special situations. We recommend creating a fast track process for Ryan White eligibility determinations for special circumstances, such as when an individual has recently relocated to Houston and/or has fallen out of care.

Recommendation 7: Increase access to care for diverse populations

According to the 2016 Kinder Houston Area Survey, the Houston metropolitan area has become “the single most ethnically and culturally diverse urban region in the entire country.” Between 1990 and 2010, the Hispanic population grew from 23% to 41%, and Asians and others from 4% to 8%. It is imperative that we meet the needs of an increasingly diverse populace.¹⁰

Some specific actions include:

- Train staff and providers on culturally competent care.
- Hire staff who represent the communities they serve.
- Increase access to interpreter services.
- Develop culturally and linguistically appropriate education materials.
- Market available services directly to immigrant communities.

¹⁰ https://kinder.rice.edu/uploadedFiles/Center_for_the_Study_of_Houston/53067_Rice_HoustonAreaSurvey2016_Lowres.pdf

★ **ROADMAP** ★
TO ENDING THE HIV EPIDEMIC IN HOUSTON
-December 2016-

endhivhouston.org



**2016 Houston HIV Care
Services Needs Assessment:
Profile of Youth and Aging with HIV**

PROFILE OF YOUTH AND AGING WITH HIV

While HIV may affect people of all ages, the impact of HIV varies across age groups. The Centers for Disease Control and Prevention (CDC) report that youth aged 13 to 24 accounted for more than 1 in 5 new HIV diagnoses in 2015, with 81% of youth new diagnoses occurring among young men who have sex with men (MSM).¹ Locally, the HIV diagnosis rate for youth aged 13 to 24 in the Houston Eligible Metropolitan Area (EMA) was 32.2 new diagnoses per 100,000 population, 42% higher than the population as a whole.² People Living with HIV (PLWH) ages 45 to 54 had the highest prevalence rate of any age group within the Houston EMA in 2015 at 967.9 diagnosed cases per 100,000 population. Data about the needs and experiences of youth and those aging with HIV in the greater Houston area of particular importance to local HIV planning as this information equips communities to tailor HIV prevention and care services to meet the markedly different yet equally critical needs of these age groups.

Proactive efforts were made to gather a representative sample of all PLWH in the 2016 Houston HIV Care

Services Needs Assessment as well as focus targeted sampling among key populations (See: *Methodology*, full document), and results presented throughout the full document include participants who were recently released. This Profile highlights results *only* for participants who were youth or aging at the time of survey, as well as comparisons to the entire needs assessment sample.

Notes: “Youth” and “aging” are defined in this analysis as PLWH who indicated at survey that they were between 18 and 24 years of age for youth, and age 50 or over for aging. Data presented in this in the Demographics and Socio-Economic Characteristics section of this Profile represent the *actual* survey sample, rather than the *weighted* sample presented throughout the remainder of the Profile (See: *Methodology*, full document). Proportions are not calculated with a denominator of the total number of surveys for every variable due to missing or “check-all” responses.

¹ <https://www.cdc.gov/hiv/group/age/youth/index.html>

² Texas Department of State Health Services

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS

(Table 1) In total, 17 participants in the 2016 Houston HIV Care Services Needs Assessment were between the ages of 18 and 24 at the time of survey, while 270 were ages 50 and over. Youth comprised just over 3% of the total sample, while aging participants comprised 54%. This reflects the increasing number of aging PLWH in the Houston area.

Eighty-eight percent (88%) of youth participants and 94% of aging participants were residing in Houston/Harris County at the time of data collection. As all needs assessment participants, the majority of youth and aging participants were male (82% and 71%), and African American/Black (77% and 67%). Three aging participants and no youth participants reported being out of care. However, several differences were observed between these populations and the total sample. A greater proportion of youth participants were gay/lesbian (41% v. 34%) or bisexual (24% v. 8%), multiracial (6% v. 0.6%), and were born in the United States (100% v. 85%). There was also a greater proportion of transgender participants among the youth age group than the total sample (6% v. 4%). Compared to the total sample, higher proportions of aging participants were heterosexual (60% v. 54%)

Several socio-economic characteristics of youth and aging participants were also different from all participants. No youth participants reported having private health insurance, and a smaller proportion

reported public health insurance in the form of Medicaid and/or Medicare compared to the total sample (16% v. 50%). The average annual income among those reporting income for the total sample was \$9,380, compared to \$12,017 among youth participants and \$9,581 among aging participants. A greater proportion of aging participants (31%) reported experiencing current housing instability compared to the total sample (28%) and youth participants (18%) (*not shown*).

Characteristics of youth participants (as compared to all participants) can be summarized as follows:

- Residing in Houston/Harris County
- Male
- African American/Black
- Gay/lesbian
- With higher occurrences of no health insurance coverage, higher average annual income, and a lower proportion unstably housed.

Characteristics of aging participants (as compared to all participants) can be summarized as follows:

- Residing in Houston/Harris County
- Male
- African American/Black
- Heterosexual
- With lower occurrences of no health insurance coverage, slightly higher average annual income, and a greater proportion unstably housed.

TABLE 1-Select Participant Characteristics among Youth (18-24) and Aging (50+) participants, Houston Area HIV Needs Assessment, 2016

	Youth %	Aging %	Total %		Youth %	Aging %	Total %		Youth %	Aging %	Total %		
County of residence				Sex at birth				Primary race/ethnicity					
Harris	88%	94%	93%	Male	82%	71%	67%	White	-	14%	12%		
Fort Bend	6%	5%	4%	Female	3%	29%	38%	African American / Black	77%	67%	63%		
Liberty	6%	-	0.2%	Intersex	-	-	-	Hispanic/Latino	18%	17%	24%		
Montgomery	-	0.8%	1%	Transgender	6%	3%	4%	Asian American	-	1%	1%		
Other	-	0.8%	1%	Currently pregnant	-	-	0.2%	Other/Multiracial	6%	0.4%	0.6%		
Sexual orientation				Health insurance (multiple response)				Immigration status					
Heterosexual	29%	60%	54%	Private insurance	-	7%	7%	Born in the U.S.	100%	87%	85%		
Gay/Lesbian	41%	31%	34%	Medicaid/Medicare	16%	59%	50%	Citizen > 5 years	-	9%	7%		
Bisexual	24%	6%	8%	Harris Health System	26%	21%	24%	Citizen < 5 years	-	0.4%	0.8%		
Other	6%	3%	5%	Ryan White Only	53%	12%	17%	Undocumented	-	2%	2%		
MSM	77%	37%	43%	None	5%	0.3%	1%	Prefer not to answer	-	0.7%	4%		
Yearly income (average: \$9,380)												Other	2%
Yearly income – Youth (average: \$12,017)													
Yearly income – Aging (average: \$9,581)													
Below 100%	71%	78%	79%										
100%	-	13%	13%										
150%	14%	3%	4%										
200%	-	3%	3%										
250%	14%	0.5%	0.6%										
≥300%	-	1%	1%										

BARRIERS TO RETENTION IN CARE

As in the methodology for all needs assessment participants, results presented in the remaining sections of this Profile were statistically weighted using current HIV prevalence for the Houston EMA (2014) in order to produce proportional results (See: *Methodology*, full document).

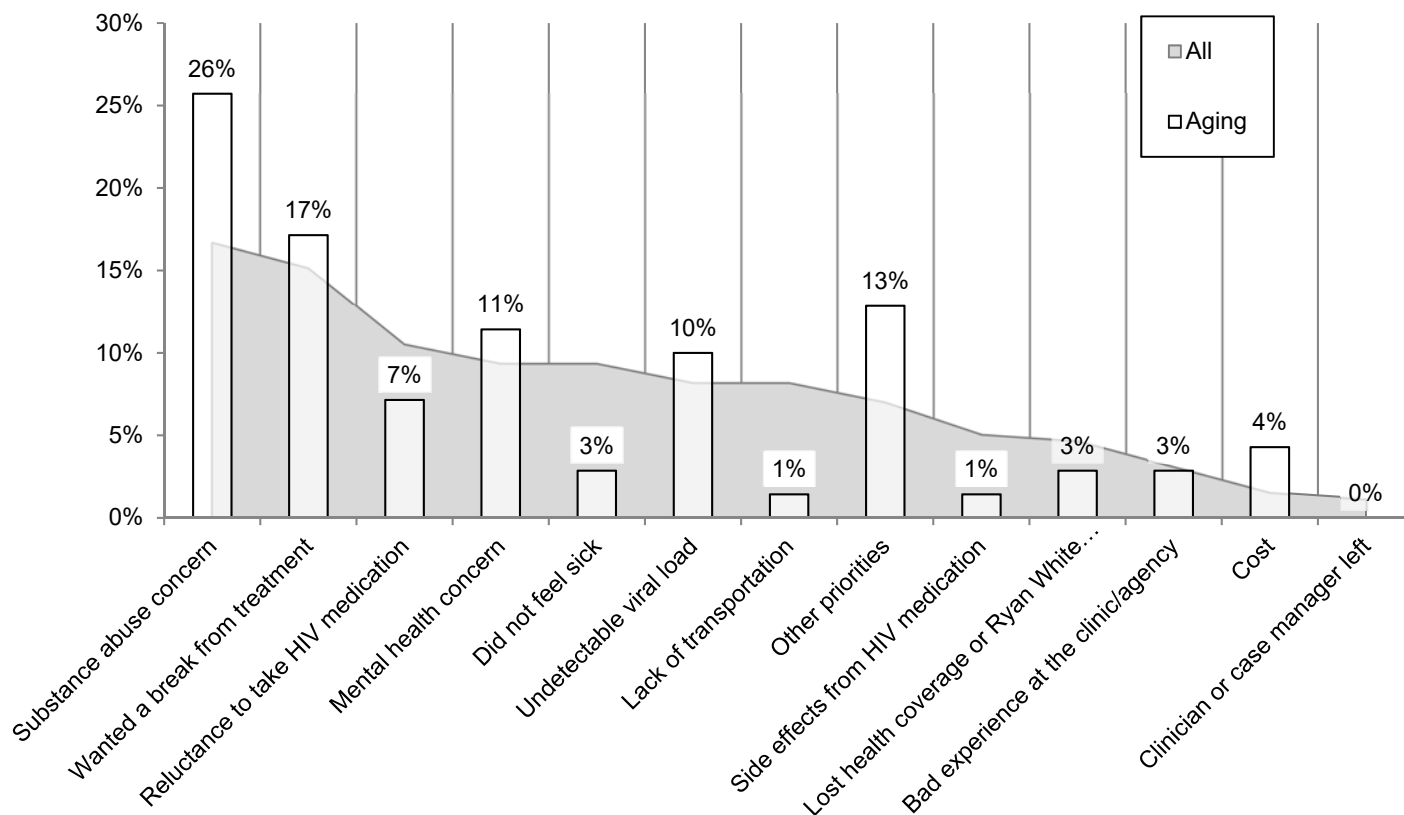
While 71% of needs assessment participants reported no interruption in their HIV care for 12 months or more since their diagnosis, 75% of both youth and aging participants reported no interruption in care. Those who reported a break in HIV care for 12 months or more since first entering care were asked to identify the reasons for falling out of care. Thirteen commonly reported reasons were included as options in the consumer survey. Participants could also write-in their reasons.

(Graph 1) The sample of youth participants with a history of interruption in care was too small to compare to aging participants and the total sample. Among aging participants, experiencing substance abuse concerns (26%), wanting a break from treatment (17%), having other priorities at the time (13%), experiencing mental health concerns (11%), and having an undetectable viral load (10%) were the most cited reasons for a break in HIV medical care.

Compared to the total sample, greater proportions of aging participants reported falling out of care due to substance abuse concerns, having other priorities at the time, cost, wanting a break from treatment, mental health concerns, and having an undetectable viral load. The only write-in reason for aging participants falling out of care was experiencing moving often.

GRAPH 1-Reasons for Falling Out of HIV Care among Aging PLWH in the Houston Area, 2016

Definition: Percent of times each item was reported by aging needs assessment participants as the reason they stopped their HIV care for 12 months or more since first entering care.



OVERALL RANKING OF FUNDED SERVICES, BY NEED

In 2016, 15 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Though no longer funded through the Ryan White HIV/AIDS Program, Food Pantry was also assessed. Participants of the 2016 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

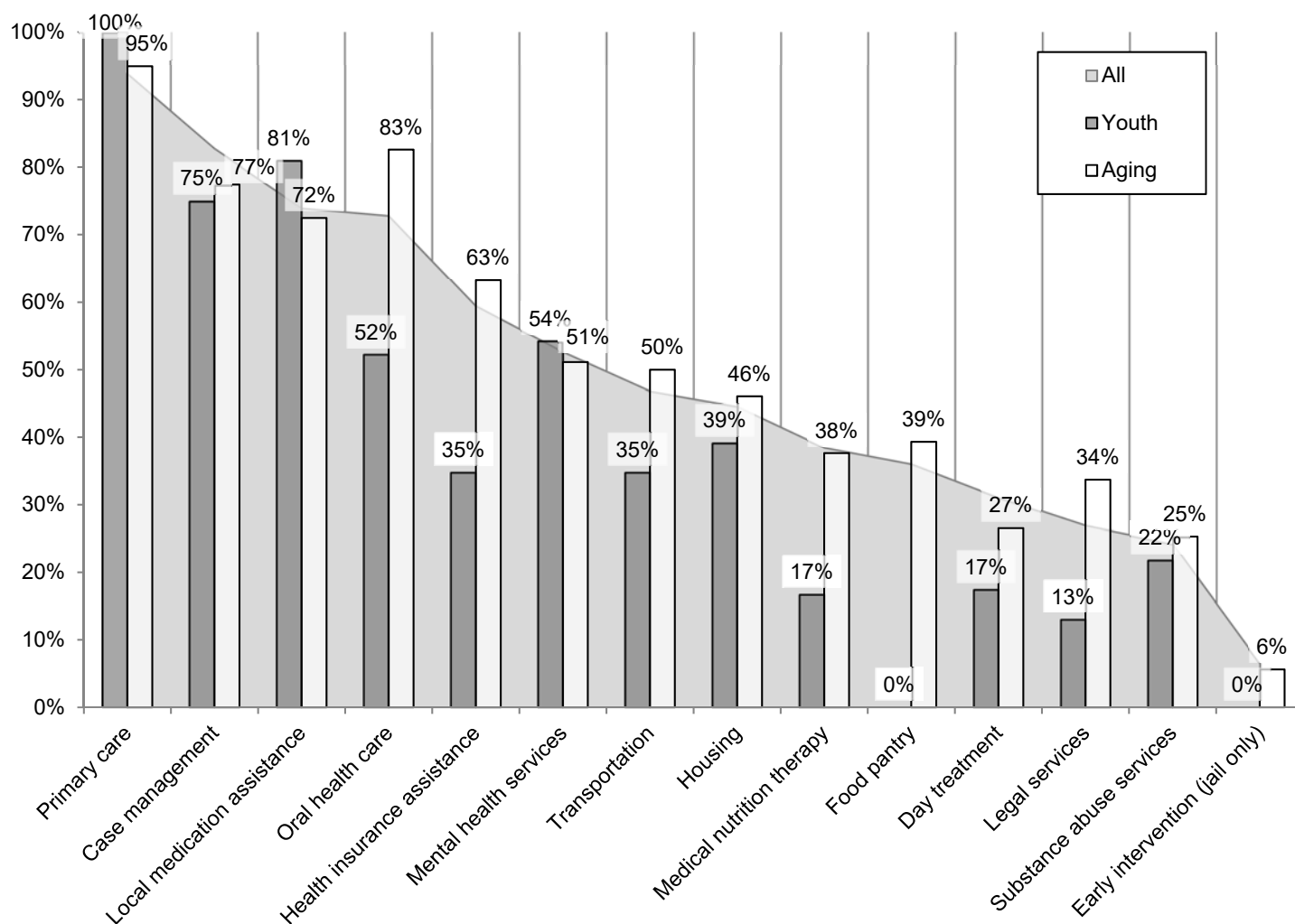
(Graph 2) Overall, youth expressed lower need for funded services compared to both the total sample and aging participants. As seen in the total sample, youth and aging participants identified primary care as the most needed funded service (100% and 95%). For youth,

local medication assistance (81%), case management (75%), mental health services (54%), and oral health care (52%) followed in ranking of need. For aging participants, oral health care (83%), case management (77%), local medication assistance (72%), and health insurance assistance (72%) followed in ranking of need.

Compared to the total sample, higher proportions of youth participants indicated needing local medication assistance, primary care, and mental health services, while higher proportions of aging participants indicated needing oral health care, legal services, health insurance assistance, transportation, food pantry, housing, primary care, and substance abuse services.

GRAPH 2-Ranking of HIV Services among Youth and Aging PLWH in the Houston Area, By Need, 2016

Definition: Percent of youth and aging needs assessment participants stating they needed the service in the past 12 months, regardless of ease or difficulty accessing the service.



Other Identified Needs

Twelve other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for Houston Area PLWH. Participants were also encouraged to write-in other types of needed services.

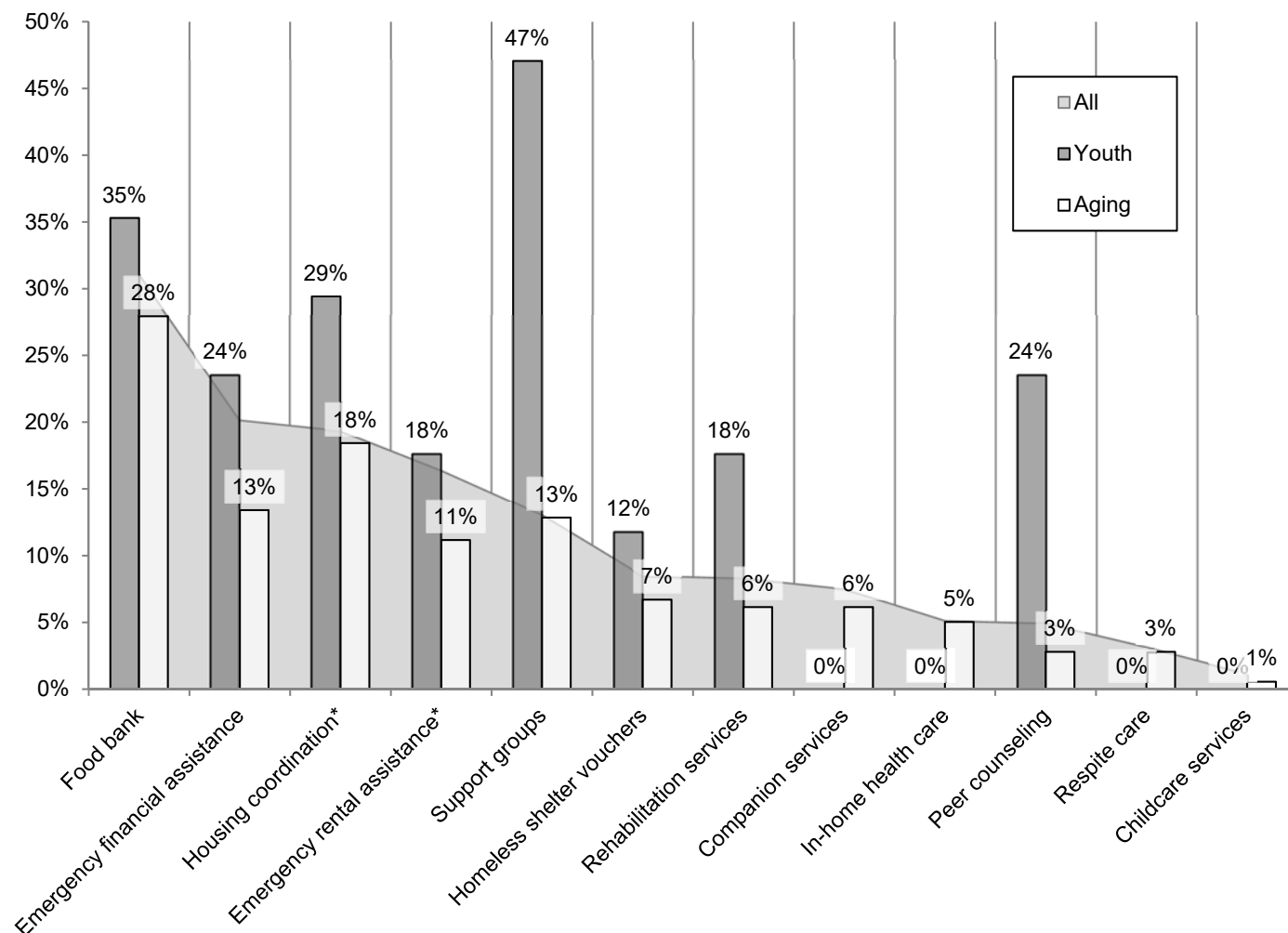
(Graph 3) From the 12 services options provided, the greatest proportion of youth participants reported needing support groups (47%), followed by food bank (35%), housing coordination (29%), emergency financial assistance (24%), and peer counseling (24%). This may indicate a need for peer-to-peer support and counseling among young PLWH in the Houston Area. Aging participants indicated needing food bank (28%), followed by housing coordination (18%), emergency financial assistance (13%), support groups (13%), and emergency rental assistance (11%).

While aging participants reported comparable or lower need for other services compared to the total sample, youth expressed a higher need for other/non-Ryan White funded HIV-related services. Greater proportions of youth participants reported needing support groups (47% v. 13%), peer counseling (24% v. 5%), housing coordination (29% v. 19%), rehabilitation services (18% v. 8%), food bank (35% v. 31%), emergency financial assistance (24% v. 20%), homeless shelter vouchers (12% v. 8%), and emergency rental assistance (18% v. 16%).

GRAPH 3-Other Needs for HIV Services among Youth and Aging PLWH in the Houston Area, 2016

Definition: Percent of youth and aging needs assessment participants, who selected each service in response to the survey question, "What other kinds of services do you need to help you get your HIV medical care?"

*These services are not currently funded by the Ryan White program; however, they are available through the Housing Opportunities for People with AIDS (HOPWA) program.



OVERALL BARRIERS TO HIV CARE

For the first time in the Houston Area HIV Needs Assessment process, participants who reported *difficulty* accessing needed services were asked to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Recursive abstraction was used to categorize participant descriptions into 39 distinct barriers. These barriers were then grouped together into 12 nodes, or barrier types.

(Graph 4) Youth participants reported encountering 11 barriers to the services, while aging participants reported encountering 278 barriers. This difference is likely an artifact of the sample size for each age range, but may also be reflective of the lower need for funded services reported among youth participants. (See: *Demographics and Socio-economic Characteristics* and *Overall Ranking of Funded Services, By Need*, above).

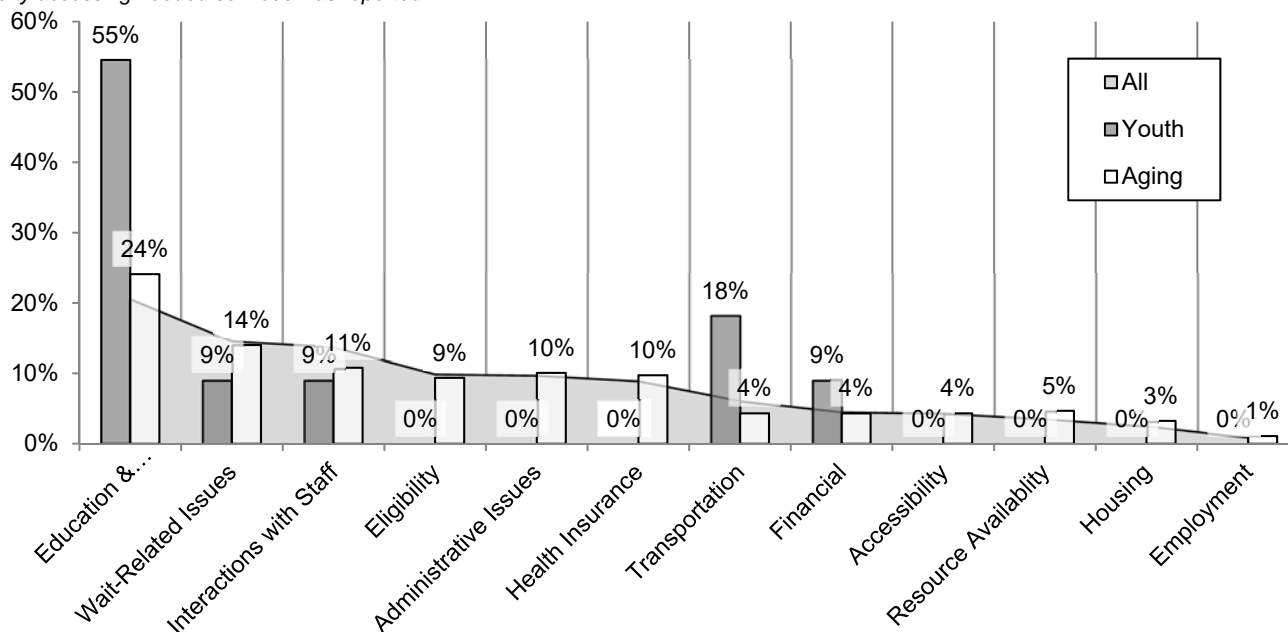
Overall, the barrier types reported most often among youth participants related to service education and awareness issues (55% of reported barriers, n=6 reports), and transportation issues (18%, n=2). Education and awareness barriers reported were most often not knowing where particular services are located.

The barrier types reported most often among aging participants related to education and awareness issues (24% of reported barriers, n=67), wait-related issues (14%, n=39), interactions with staff (11%, n=30), administrative issues (10%, n=28), and health insurance issues (10%, n=27). Education and awareness barriers among aging participants most often pertained to being unaware that a particular service was available. Aging participants reporting wait-related issues most often referred to being placed on a waiting list. Most often barriers relating to interactions with staff were reported as poor communication or follow-up from staff. Administrative barriers for aging participants related most often to long complex processes encountered to access services. The most common barrier related to eligibility among aging participants was being ineligible for the service.

While the number of barrier reports among youth participants is too low for comparison to the total sample, a greater portion of aging participants compared to the total sample reported education and awareness related barriers (24% vs. 21%).

GRAPH 4-Ranking of Types of Barriers to HIV Services among Youth and Aging PLWH in the Houston Area, 2016

Definition: Percent of times each barrier type was reported by youth and aging needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



**For more information or a copy of the full 2016 Houston
HIV Care Services Needs Assessment contact:**

Houston Area Ryan White Planning Council

2223 West Loop South #240

Houston, TX 77027

Tel: (713) 572-3724

Fax: (713) 572-3740

Web: www.rwpchouston.org

2018 University of Texas, UT-Austin

Micro-Grant "Empowering Community Action Project"

MYSTERY SHOPPERS

A

LATINO HIV TASK FORCE

Innovative Micro-Grant Project

The Latino HIV Task Force (LHTF) was a recipient of the 2018 UT-Austin Micro-Grant: Empowering Community Action. This Award allowed LHTF to address the impact of HIV among Latino Gay and Bi-sexual Men, Other Men who have Sex with Men (MSM), and Transgender individuals in Houston. Latino comprise of approximately 37% of the total population in Houston according to the 2000 Census with 679,292 of Latinos identifying as Spanish speaking only. A large majority of Latino Gay and Bi-Sexual Men, MSM, and Transgender individuals in Houston are Bilingual in Spanish and English, of working class, or live in extreme poverty. The role of immigration in these groups is structurally related to HIV due to the level of education, income, and employment factors impacting this Latino Subgroup. Many Latinos are fearful of accessing any medical or social services and will wait until it is absolutely necessary. In most cases, they are fearful of coming forward due to the shortage of Spanish-speaking providers and anti-immigration sentiment in the states. In hindsight, the Latino HIV Task Force would like to implement a non-traditional approach that is unrecorded in the HIV industry and place Mystery Shoppers into operation accessing medical care and/or social services. Mystery Shoppers perform specific tasks such as purchasing a product, asking questions, registering complaints or behaving in a certain way, and then provide detailed reports or feedback about their experiences. It is consistently reported that many MSM and Male To Female, MTF Transgender identified individuals find it difficulty in accessing services, when they are Monolingual-Spanish speaking only. In this opportunity, Mystery Shoppers raised awareness of the factors that contribute to the disproportionate burden of HIV treatment and services. These Mystery Shoppers also addressed social justice issues that contribute to the HIV epidemic. The results will provide supportive documentation and testimony on ways the Latino HIV Task Force can work with the identified agencies to advocate change in barriers to care.

Mystery Shoppers were placed to receive services in the community agencies and provide insight into overall available health and social services. These services assist in reducing health gaps caused by income, education, race, ethnicity, and sexual orientation. The Latino HIV Task Force is a visible avenue embedded in HIV advocacy and awareness activities in Houston. The LHTF in collaboration with the Mystery Shoppers served to maximize the impact of our effort through our established collaborations with volunteers and organizations in the community. The Mystery Shoppers assisted in identifying reconciliation of this language barrier with participation in this project.

Gloria Sierra, chair of the Latino HIV Task Force along with Cynthia V. Agurries, LHTF Member, interviewed several Latino MSM and MTF Transgender to commit and participate as a Mystery Shopper for this project. We recruited and trained eight (8) Mystery Shoppers that included three (3) MSM and five (5) MTF Transgender. Each participant was asked to evaluate the HIV social services by visiting three (3) agencies. They were to remain courteous and non-threatening at all times during their visits. They recorded their experiences using a checklist and a set of questions that were approved by the Award committee. The Mystery Shopper's goals were to provide insight on how employees care for Spanish speaking potential clients and what type of information is provided when approached with this special interest group. They also assisted in identifying training needs to improve professionalism in customer service, knowledge in cultural differences and achieving quality access to services and care in a timely manner. They also assessed the agencies geographically accessibility, the appointment setting schedule for immediate or walk-in appointments and what available services the agency advertises and offers their patrons.

The Mystery Shopper introduced him/herself, provided context about their needs, inquired about available services and how to obtain them. The Mystery Shopper documented the overall interaction of the visit which included: the provider temperament, was there information available reflecting all populations in the waiting area, what was the receptionist tone of voice when approached, their willingness to assist, whether they answered their questions, and whether or not they were provided with the preferred service and the overall result of the visit.

See attached for Mystery Shopper Questions and Performance Card.

Disclosure:

The following pages are the results as provided by the Mystery Shopper Participants.

The Latino HIV Task Force, LHTF liability is to report results of the UT Micro-Grant to the LHTF Members as written in the contractual agreement and is not intended for reproducing for dissemination and slander to the Agencies Identified.

This information is intended for awareness and training for Agencies who serve Latino and special interest populations.

MSM: R (English & Spanish language)

First Agency:

Spoke with a staff member who is a Spanish speaker, who was very courteous, engaging and inquired about their needs and how the new _____ would meet their needs. Although he didn't inform him about their current programs _____ MSM was not upset because he answer his question. _____ had LGBTQ information all round and gave them information while he waited.

Second Agency:

Spoke with a nurse, English speaking but inquired if he was comfortable with Spanish then she would get another nurse. R, reported that he was fine with English. They did not have LGBTQ information in their lobby or waiting area. They were aware of his sexual orientation and status to arrange counseling service for him. A short waiting period, about 2 weeks which he schedule an appointment and follow-up with him after a week to schedule with therapist.

Third Agency:

Called and spoke with front desk who did speak Spanish but was not courteous in her interactions. His experience was the same when he went in to meet with financial counselor: Staff. Lobby did not have any LGBTQ information or material on their programs. Reported that they took all his information but never returned his calls, assist him with his rent or let him know that they could not assist him.

MSM: O (English & Spanish)

First Agency:

He attempted to call first to schedule an appointment, but they never answer their phone or could not leave a message. He walked in to get testing, they were very courteous but did not engage in conversation or inquired about needs like getting condoms or did not speak to him about safer sex practices. Gave him information about all the testing that they provide. A longer wait time than planned. Their lobby was full of flyers on STI, Substance abuse, Mental Health, and LGBTQ)

Second Agency:

Front staff was not engaging or courteous. They reported that he could not just walk in and expect to be seen after a 7 min wait time in speaking with him. He went in November 13 and reported that their first available appointment would not be until November 30 for PrEP information. Another employee heard interaction and came to speak to him about PrEP, he was very friendly asked him what he would like to know and then provided him with the information necessary to make an informed decision about PrEP.

Third Agency:

Mystery shopper O did not call, he walked in to inquire about an appointment. He went in November 19 @ 9:00 AM and reported that the front desk personal was very friendly but did not ask him his name. She stated that there were no appointment available until December 6, thou did not ask to if he would like to schedule an appointment.

Transgender: B (Spanish)

First Agency:

She walked in to get financial assistance but was told that they only have programs for drug and alcohol. They did not have information in the lobby, nor pamphlet that focus on LGBTQ in English or Spanish. Front Desk was not rude but just was not helpful in asking what her needs were but stated that maybe someone could help her in two weeks. She walked in November 20 but could not speak to anyone until December 9 @ 10:00 AM.

Second Agency:

B walked in to get information on STIs & PrEP testing, she reported that she was not here legally, and could they still assist her in getting tested. They did requested information of her income, an ID, and where she lived. They had several information on LGBTQ in their lobby and offices. She reported that they were all helpful the only issue she had with them with that she had to wait for 20 minutes. They also were not sensitive to calling her by her name but her name on her ID.

Third Agency:

B went in to seek information on whether she could participate in programs at this location since it offers women issues. They welcome her and replied that the only issue would be that they could not do a physical exam but offered her to get her exams at their Montrose location and then participate in their programs. They offered information on their programs, there were several information on LGBTQ but nothing specific on Transgender (she acknowledges that she has never seen any). They also stated that because it was the holidays that new groups were not beginning until January. They did use her preferred name.

Transgender: B2 (Spanish)

First Agency:

No one spoke Spanish, no one could find anyone to assist her and asked her to come back tomorrow or maybe later. She went back two days later and still no one spoke Spanish.

Second Agency:

Front desk was very helpful at both places, she arrived at [redacted] to get dental services but was told that she had to get dental services at their [redacted] location. They were very courteous and called her by her preferred name, but their application did not have a preferred name. She would be assisted but their wait time was 6 months and their fee would be \$99.

Third Agency:

No Spanish speaker readily accessible and had to wait 20 minutes and took her to the second floor to and spoke with Gilbert. Their application also did not have a preferred name, but they did call her by her preferred name. She said that he was very helpful and even when they reported that she would have to pay, he said that they would work with her in payments. They did have a wait time and it was 6 months. B reported that she loved their attentiveness and felt very comfortable. She did recommend that they have a pamphlet with all their programs since they did leave her alone for 2 hours. That was all her complain about [redacted] the wait time, but their helpfulness made up for that.

Transgender: S (Spanish)

First Agency:

No Spanish speaker until 45 minutes later. Once they had a Spanish speaker, they were very friendly and assisted them with getting information on getting vision services. They were called by their preferred name but not on their application, used their ID. Had a two month wait time but scheduled their appointment.

Second Agency:

The two people in the front did not want to help her at all. Were frustrated that they had to assist her because she did not speak English. Would not even come to the window to come and ask what she needed. S stated that she understood a little English, then became rude stating that she needed to bring a bill, paycheck stuff or an apartment contract in order to get any kind of assistance. She replied that she needed PrEP information, the nurse in the back told her to come back to tomorrow to maybe get some help. Would not call her by preferred name.

Third Agency:

Their website stated that their address was at one address, but they were not there, and she had to go to another location. They did have someone that spoke Spanish but was upset that she had to speak to her in Spanish. She told a co-worker "that they come over here and don't learn English and expect to be helped". All this was at their location once she when to location they asked her about her needs but stated that they did have a wait time of 3 weeks for a dental visit. She stated that she would never use their location again because of how rude their front desk was.

Transgender: A (English & Spanish)

First Agency:

They were very courteous and called her by her preferred name. They did not engage her in what her needs were but did ask why she was there or what she needed. They were friendly and did speak Spanish and began with that until she reported that she spoke English as well. She did not have to wait expect maybe 10 minutes.

Second Agency:

A went in to get information on Immigration services through their attorneys. They had no wait time and they were very helpful and called her by her preferred name. They spoke to her in Spanish until she stated that she spoke English.

Third Agency:

A went in for housing information because she had just moved from California to Texas and she gave her a place to stay for two weeks until she was able to get herself together. Information on programs was there and they helped her get a job that she still has after three years in Texas.

Transgender D (Spanish)

First Agency:

D called to schedule an appointment and given one that accommodated her schedule. They were very courteous and gave her information on Wills. The front desk did not engage or inquire about her needs but did state that the attorney would follow-up when they called to see what she needed.

Second Agency:

They had to get someone who spoke Spanish to assist her, she was sorry that she could not get someone faster for her. They did not have a Spanish Support Group but did call her by her preferred name. She was referred to Family Service Center who had counselors who spoke Spanish.

Third Agency:

D called and they had someone who spoke Spanish, she wanted information on getting tested and information on PrEP. She was told that she could come in and someone would speak with her. They called her by her preferred name and reported no charge for her. They had information on LGBTQ and programs that they offered. She was tested and placed on PrEP.

MSM: E (Spanish a little English)

First Agency:

No Spanish person at front desk and very rude about it stating that he needed to learn English before he informed them that he did speak a little English. Not courteous at all quite rude. They called a community worker who was very friendly and helpful and gave him a lot of information about PrEP and inquired about his needs but never offered him condoms.

Second Agency:

Once again front desk at _____ was quite rude and stated that they cannot just walk in without making an appointment. Gave him a business card and told him to call and make an appointment and left the front desk with him standing there.

Third Agency:

No Spanish speaker but shared that he spoke a little English. They were very helpful, and he felt comfortable and never felt that they did not want to assist him. They offered him so much food and he was so thankful. The only thing he stated is that they did not inform about their other programs and how he may have access them.

Training Protocol

A Framework for conducting mystery shoppers to HIV services funds. The LHTF will provide knowledge related to:

Access to care standards:

- ✓ Timely access to services
- ✓ Geographic access to services
- ✓ HIV requirements for Transgender and MSM populations
- ✓ Ability to schedule appointment
- ✓ Delivery of services
- ✓ Available services for MSM and Transgender Latino's.

Mystery shopper will represent him/her as an individual seeking services.

The mystery shopper can be one member or a two-team member with the second member taking notes and complete the evaluation.

Calls will be evaluated bases on:

- Professionalism-courteous, informative, and clear
- Timeliness to service appointment

Mystery shopper will:

- Introduce him/herself
- Provide context around their needs
- Remain courteous
- Inquire about available services options to address needs identified and
- Inquire about how to obtain services.

Documentation should consist of:

- Temperament and tone of voice
- Willingness to assist
- Ability to answer the caller's questions and
- Active listening skills

LHTF Team Leaders will compile the finding from the calls and present this information to UT.

Question for Mystery Shoppers

I was able to schedule an appointment via phone, online, or walk in were welcome

How long did it take to wait for an appointment? (in days)

Was the provider near public transportation?

Were the office staff friendly?

Was the office staff judgmental?

The office staff were not LGBTQ sensitive.

LGBTQ visibility: did the waiting room has posters aimed at LGBTQ people (like equal sign, pink triangle, rainbow flag)

Is the waiting room filled with brochures and/or magazines?

Were the intake form filled with LGBTQ inclusive language

Were the intake form filled with Transgender inclusive language

Mystery Shopper Performance Card

The following section provides call details.

Date: _____ Time: _____

Agency Information:

Agency Name: _____

Address: _____

Employee Name: _____

Caller: _____

If caller indicated they were a non-English speaker, were accommodations made?

- Yes
- No
- N/A

Was the employee courteous, supplied his/her name, and spoke clearly? Yes or No

The employee attempted to engage the caller or redirect the caller? Yes or No

The employee asked questions to determine the caller's need? Yes or No

The employee provided information that was true or correct? Yes or No

If services were scheduled, the initial appointment was set for:

Within 24/48/72 hours. (select timeframe for call)

Was Mystery shopper placed on a waitlist _____

and how long was wait time. _____

Mystery Shopper: Locations**Dental:****Ave. 360 Dental Clinic**

1427 Hawthorne

77006 713-341-3790

Legacy Lyons Campus

3811 Lyons Avenue

77020 832-548-5400

or

Legacy Baker-Ripley Clinic

6500 Rookin St., Bldg B, Ste 200

77074 713-351-7350

St. Hope Foundation Bellaire

6800 West Loop, South, Suite 560

Bellaire, 77401 713-839-7111

or

St. Hope Sugarland

13020 Dairy Ashford Rd, Ste 100

Sugar Land 77478 281-277-8571

Eye Care:**Legacy Montrose Campus**

1415 California St

77006 832-548-5100

&

St. Hope Bellaire & Sugarland**Financial Assistance:****Brentwood Project WAITT**

13101 Landmark St

77045 713-852-2551

or

Catholic Charities HIV/AIDS

2900 Louisiana St

77006 713-874-6724

Housing:**Ave. 360****Brentwood Project WAITT****Catholic Charities**

Mental Health Counseling & Treatment:

Ave. 360

Catholic Charities

Legacy Baker-Ripley, Lyons, & Montrose Center

Montrose Center

401 Branard St., 2nd Floor

77006 713-529-0037

St. Hope Foundation Bellaire & Sugarland

AAMA (Association for the Advancement of Mexican American

204 Clifton St

77011 713-926-9491

AIDS Foundation Houston (AFH)

6260 Westpark Drive, Suite 100

77057 713-623-6796

AIDS Healthcare Foundation (AHF)

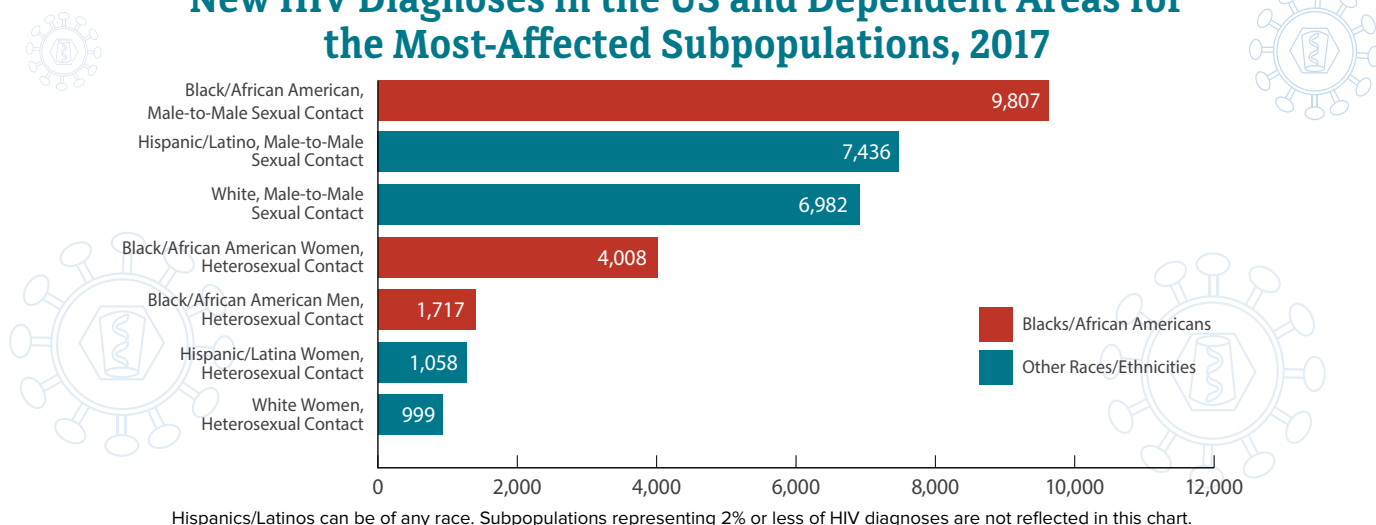
1200 Binz Street, Suite 1290

77004 713-524-8700

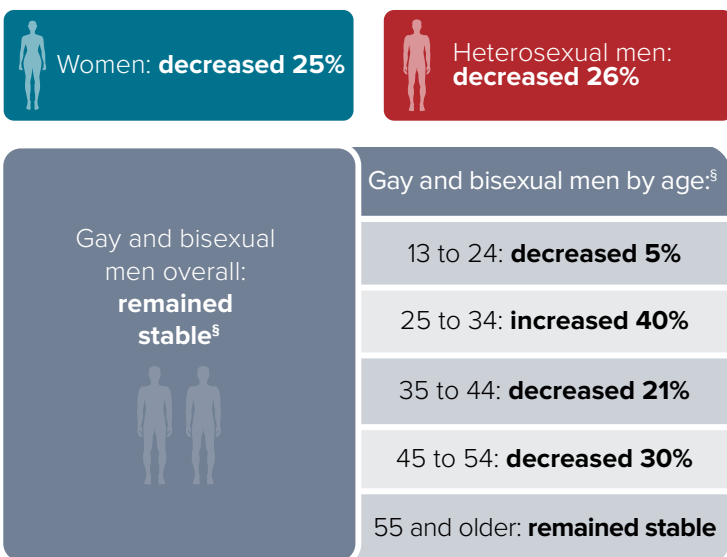
HIV and African Americans

Of the 38,739 new HIV diagnoses in the US and dependent areas* in 2017, **16,694 (43%) were among blacks/African Americans.****

New HIV Diagnoses in the US and Dependent Areas for the Most-Affected Subpopulations, 2017



From 2010 to 2016, HIV diagnoses decreased 12% among blacks/African Americans overall.[†] But trends varied for different groups of blacks/African Americans.



* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

** *Black* refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean, and South and Latin America. *African American* is a term often used for Americans of African descent with ancestry in North America. Individuals may self-identify as either, both, or choose another identity altogether. This fact sheet uses *African American*, unless referencing surveillance data.

[†] In 50 states and District of Columbia.

[§] Includes infections attributed to male-to-male sexual contact and injection drug use (men who reported both risk factors).

Around 1.1 million people are living with HIV in the US.[†] People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.



A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.

Why are African Americans at higher risk?

- 1 in 7 blacks/African Americans with HIV are unaware they have it. People who do not know they have HIV cannot take advantage of HIV care and treatment and may unknowingly pass HIV to others.
- Some African American communities continue to experience higher rates of other sexually transmitted diseases (STDs) when compared to other races/ethnicities. Having another STD can significantly increase a person's chance of getting or transmitting HIV.
- Limited access to quality health care, lower income and educational levels, and higher rates of unemployment may place some African Americans at higher risk for HIV.
- Stigma, fear, discrimination, and homophobia may also place many African Americans at higher risk for HIV.

How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends among African Americans.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments and community organizations by funding HIV prevention work for African Americans and providing technical assistance.
- Supporting community organizations that can increase access to HIV testing and care and other services for African Americans.
- Promoting testing, prevention, and treatment through campaigns like *Act Against AIDS*.

AT THE END OF 2015,
AN ESTIMATED
468,800

BLACKS/AFRICAN AMERICANS
HAD HIV.[†]

6 in 7
KNEW THEY HAD THE VIRUS.

FOR EVERY 100
BLACKS/AFRICAN
AMERICANS
WITH HIV IN 2015:[†]



Reduce Your Risk



Not having sex



Using condoms



Not sharing syringes



Taking medicine to prevent or treat HIV

HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit gettested.cdc.gov to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

For More Information

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

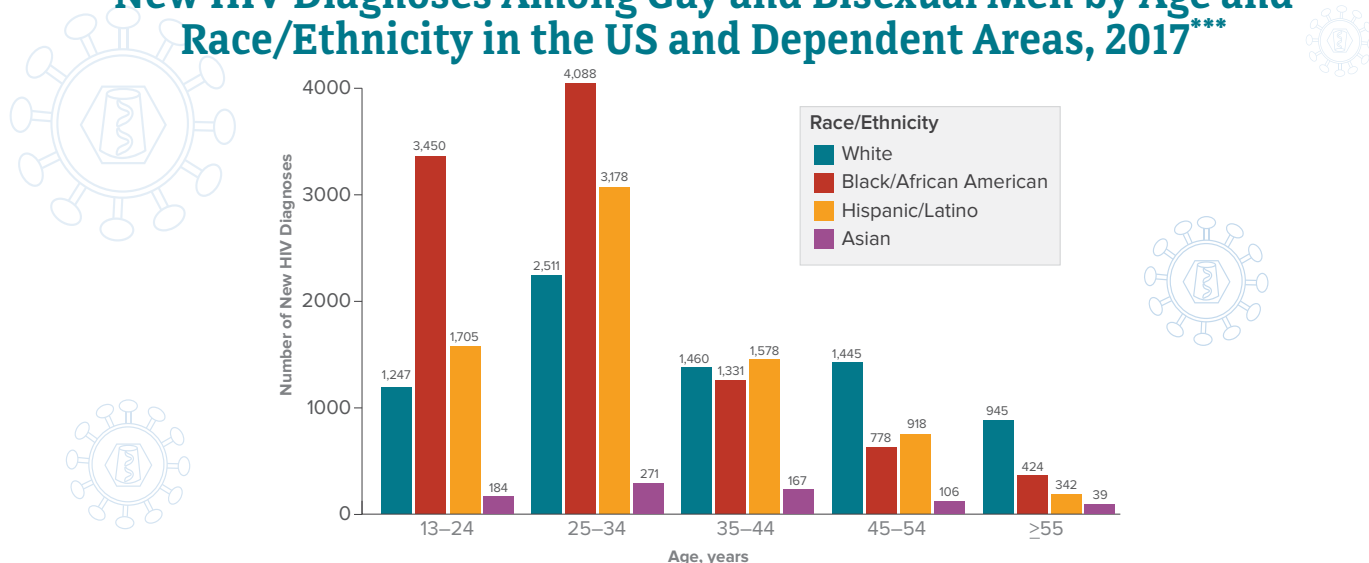
HIV and African American Gay and Bisexual Men

Of the 38,739 new HIV diagnoses in the US and dependent areas* in 2017, **10,070 (26%) were among black/African American** gay and bisexual men.*****

Black/African American gay and bisexual men made up 34% of HIV diagnoses among all gay and bisexual men

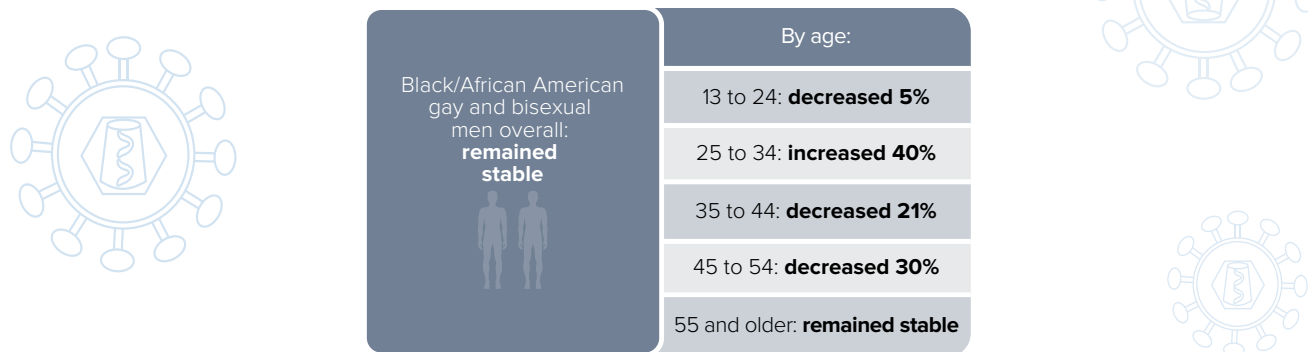
3 out of 4 black/African American gay and bisexual men who received an HIV diagnosis were aged 13 - 34

New HIV Diagnoses Among Gay and Bisexual Men by Age and Race/Ethnicity in the US and Dependent Areas, 2017***



Subpopulations representing 2% or less of HIV diagnoses among gay and bisexual men are not reflected in this chart. Hispanics/Latinos can be of any race.

From 2010 to 2016, HIV diagnoses remained stable overall among black/African American gay and bisexual men.*** † But trends varied by age.



* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

** *Black* refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean and South and Latin America. *African American* is a term often used for Americans of African descent with ancestry in North America. Individuals may self-identify as either, both, or choose another identity altogether. This fact sheet uses *African American*, unless referencing surveillance data.

*** Includes infections attributed to male-to-male sexual contact and injection drug use (men who reported both risk factors).

† In 50 states and District of Columbia.



Around 1.1 million people are living with HIV in the US.[†] People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.



A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.

What places some African American gay and bisexual men at higher risk?

- Many African American gay and bisexual men do not know their HIV status. People who do not know they have HIV cannot get the treatment they need and may pass the infection to others without knowing it.
- African American gay and bisexual men have lower rates of viral suppression compared to gay and bisexual men of other races/ethnicities. Because of the low rates of viral suppression, greater number of people with HIV in that population, and the greater likelihood of having sex partners of the same race, compared with other races/ethnicities, African American gay and bisexual men have a greater chance of coming in contact with HIV.
- Limited access to quality health care, lower income and educational levels, and higher rates of unemployment and incarceration may place some African American gay and bisexual men at higher risk for HIV.
- Stigma, homophobia, and discrimination put gay and bisexual men of all races/ethnicities at risk for many health issues and may affect whether they are able to get quality health care.

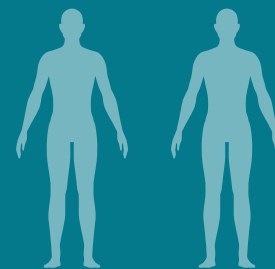
How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends among African American gay and bisexual men.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments and community organizations by funding HIV prevention work for African American gay and bisexual men and providing technical assistance.
- Promoting testing, prevention, and treatment through campaigns like *Act Against AIDS*.

[†] In 50 states and District of Columbia.

^{**} "4 in 5" (80%) includes infections attributed to male-to-male sexual contact. Among men with HIV infection attributed to male-to-male sexual contact *and* injection drug use, 95% knew they had HIV.

AT THE END
OF 2015,
AN ESTIMATED
218,600
BLACK/AFRICAN
AMERICAN
GAY AND
BISEXUAL MEN
HAD HIV.[†]



4 in 5
KNEW THEY HAD THE VIRUS.^{**}

Reduce Your Risk



Not having sex



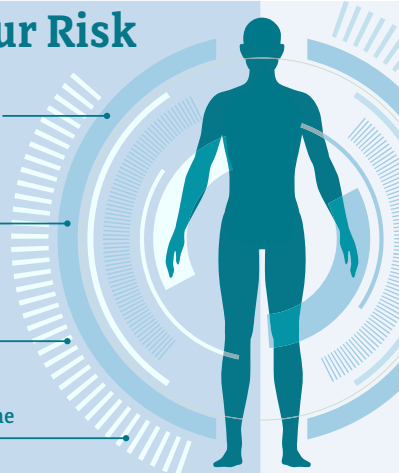
Using
condoms



Not sharing
syringes



Taking medicine
to prevent
or treat HIV



HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit gettested.cdc.gov to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

For More Information

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

HIV and Hispanics/Latinos

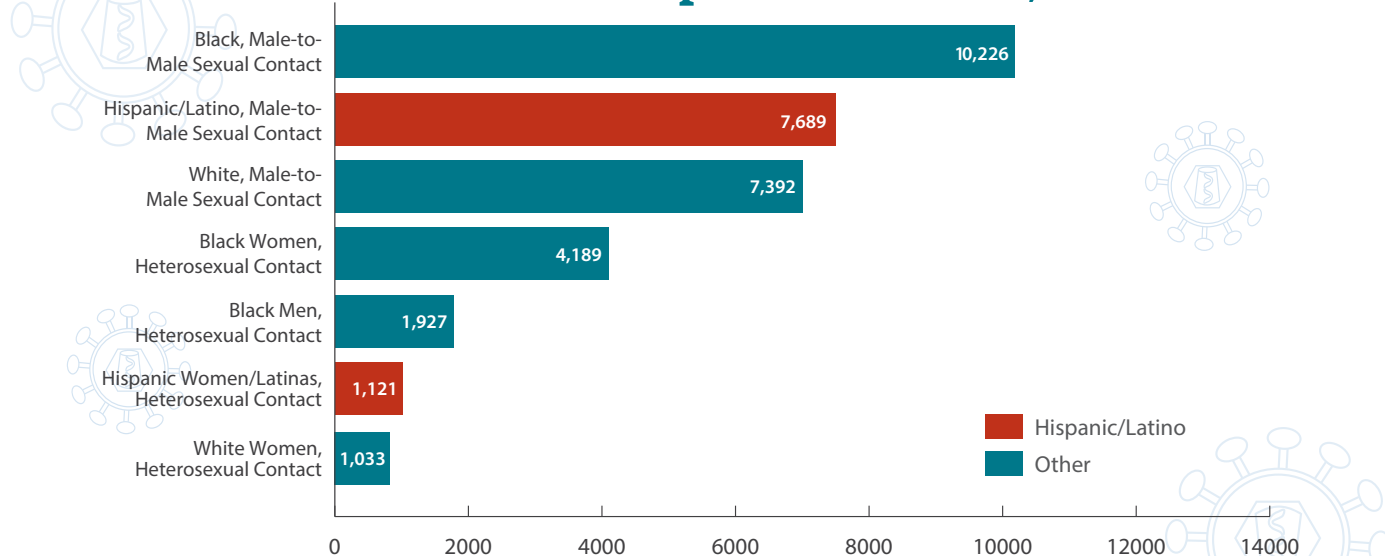
OF THE 40,324 HIV DIAGNOSES IN THE US AND 6 DEPENDENT AREAS IN 2016:*

10,292 (26%) WERE AMONG HISPANICS/LATINOS**

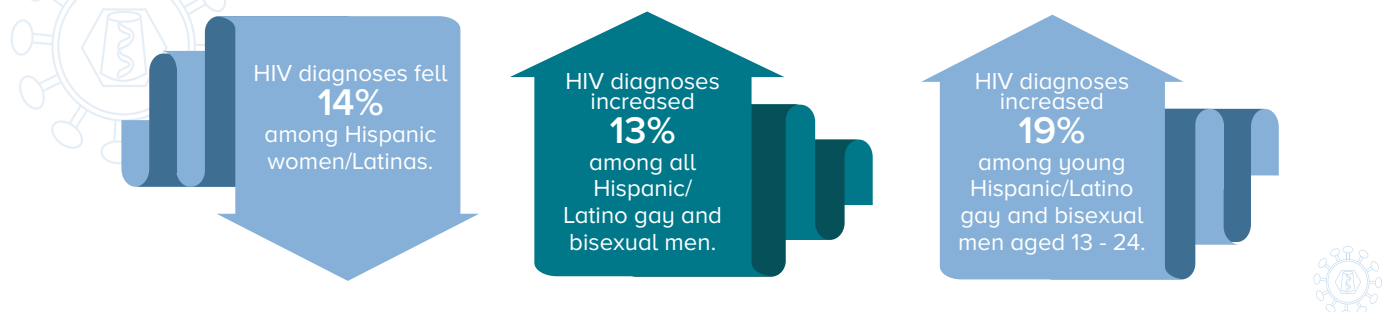
8,999 (22%) WERE AMONG HISPANIC/LATINO MEN

1,277 (3%) WERE AMONG HISPANIC WOMEN/LATINAS

HIV Diagnoses Among the Most-Affected Subpopulations in the US and 6 Dependent Areas, 2016



From 2011 to 2015, HIV diagnoses remained stable among all Hispanics/Latinos.



* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

** Hispanics/Latinos can be of any race.

Around 1.1 million people have HIV in the US.[†] People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.



A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.

What places some Hispanics/Latinos at higher risk?

- Many Hispanics/Latinos do not know their HIV status. People who do not know they have HIV cannot get the treatment they need and may pass the infection to others without knowing it.
- More Hispanics/Latinos have HIV compared to some other races/ethnicities. Therefore, Hispanics/Latinos have an increased chance of having an HIV-positive partner if they have other Hispanic/Latino partners.
- Hispanics/Latinos have higher rates of some STDs. Having another STD can increase a person's chance of getting or transmitting HIV.
- Poverty, migration patterns, lower educational level, and language barriers may make it harder for some Hispanics/Latinos to get HIV testing and care.
- Stigma, fear, discrimination, and homophobia may impact the lives of some Hispanics/Latinos. These issues may put some Hispanics/Latinos at higher risk for HIV infection.

How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends among Hispanics/Latinos.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments and community organizations by funding HIV prevention work for Hispanics/Latinos and providing technical assistance.
- Supporting community organizations that can increase access to HIV testing and care and other services for Hispanics/Latinos.
- Promoting testing, prevention, and treatment through campaigns like *Act Against AIDS*.

[†] In 50 states and District of Columbia.

Reduce Your Risk



Not having sex



Using condoms



Not sharing syringes



Taking medicine to prevent or treat HIV



HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit gettested.cdc.gov to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

AT THE END OF 2015,
AN ESTIMATED
252,400
HISPANICS/LATINOS
HAD HIV.[†]

5 in 6
KNEW THEY HAD THE VIRUS.

FOR EVERY 100
HISPANICS/LATINOS
WITH HIV IN 2015:[†]



received
some
HIV care



were
retained
in care



were virally
suppressed

For More Information

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

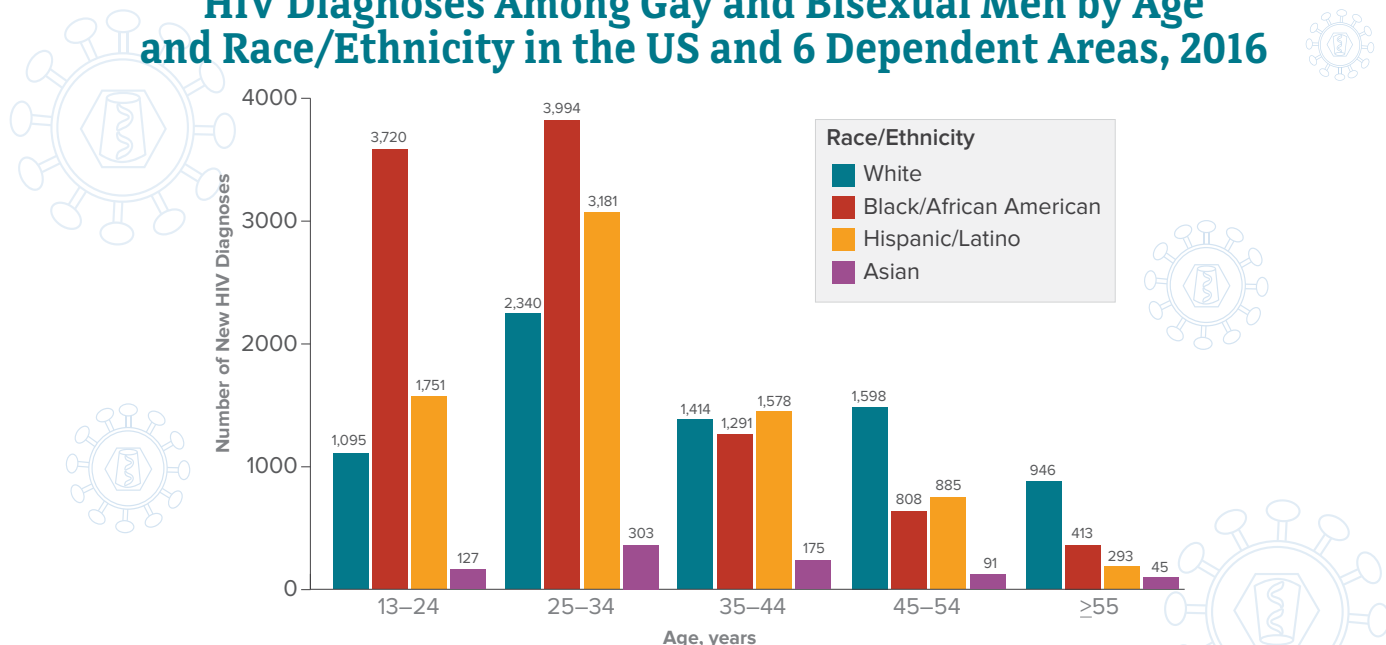
HIV and Hispanic/Latino Gay and Bisexual Men

**OF THE 40,324 HIV DIAGNOSES IN THE US AND 6 DEPENDENT AREAS IN 2016:*
7,689 (19%) WERE AMONG HISPANIC/LATINO** GAY AND BISEXUAL MEN**

HISPANIC/LATINO GAY AND BISEXUAL MEN ACCOUNTED FOR 29% OF HIV DIAGNOSES AMONG ALL GAY AND BISEXUAL MEN

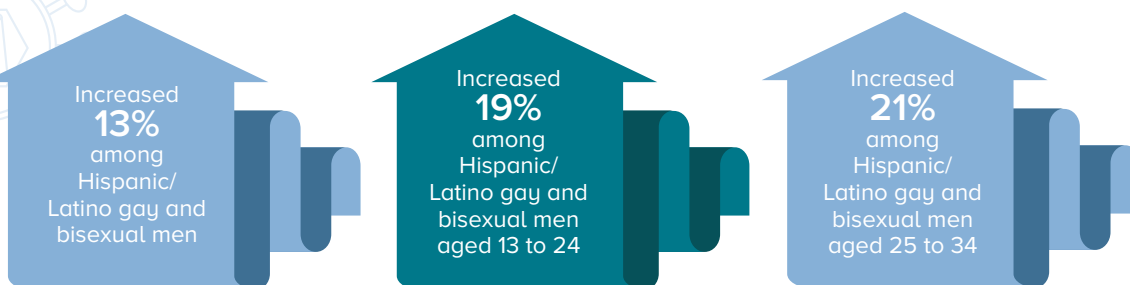
ABOUT 2 OUT OF 3 HISPANIC/LATINO GAY AND BISEXUAL MEN WHO RECEIVED AN HIV DIAGNOSIS WERE AGED 13 - 34

HIV Diagnoses Among Gay and Bisexual Men by Age and Race/Ethnicity in the US and 6 Dependent Areas, 2016



Subpopulations representing 2% or less of HIV diagnoses among gay and bisexual men are not reflected in this chart.

HIV Diagnoses From 2011 to 2015



* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

** Hispanics/Latinos can be of any race.

Around 1.1 million people are living with HIV in the US.[†] People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.



A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.

Why are some Hispanic/Latino gay and bisexual men at higher risk?

- An estimated 80% of Hispanic/Latino gay and bisexual men with HIV know they have it.[†] People who do not know they have HIV cannot get the treatment they need and may transmit HIV to others without knowing it.
- Hispanic/Latino gay and bisexual men are more likely to report that their last sex partner was older, compared to white or African American gay and bisexual men. Having older male partners may increase the likelihood of being exposed to HIV.
- Overall, a very small number of Hispanic/Latino gay and bisexual men reported using PrEP, and a much lower number than white gay and bisexual men.
- Poverty, migration patterns, lower educational level, and language barriers may make it harder for Hispanic/Latino gay and bisexual men to get HIV testing and care.
- Immigration status of some Hispanic/Latino gay and bisexual men may make them less likely to use HIV prevention services, get tested, or get treated if they have HIV because of lack of access.
- Stigma, homophobia, and discrimination put gay and bisexual men of all races/ethnicities at risk for many health issues and may affect whether they are able to get quality health care.

How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends among Hispanic/Latino gay and bisexual men.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments and community organizations by funding HIV prevention work for Hispanic/Latino gay and bisexual men and providing technical assistance.
- Promoting testing, prevention, and treatment through campaigns like *Act Against AIDS*.

AT THE END OF 2015,
AN ESTIMATED
151,200
HISPANIC/LATINO
GAY AND BISEXUAL MEN
HAD HIV.[†]

4 in 5
KNEW THEY HAD THE VIRUS.

FOR EVERY 100 HISPANIC/LATINO
GAY AND BISEXUAL MEN
WHO RECEIVED AN HIV DIAGNOSIS
IN 2013 OR EARLIER:[‡]



[†] In 50 states and District of Columbia

[‡] In 37 states and District of Columbia. These jurisdictions are included because they had complete reporting of CD4 and viral load results to CDC.

Reduce Your Risk



Not having sex



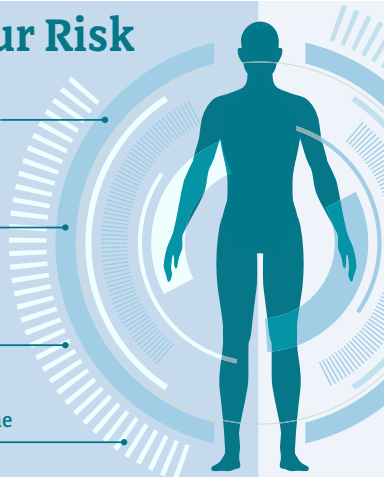
Using
condoms



Not sharing
syringes



Taking medicine
to prevent
or treat HIV



HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit gettested.cdc.gov to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

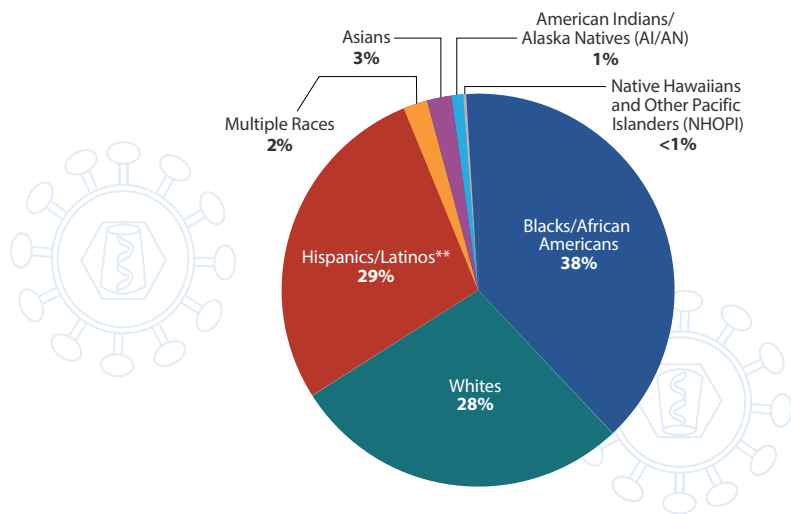
For More Information

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Visit www.cdc.gov/hiv

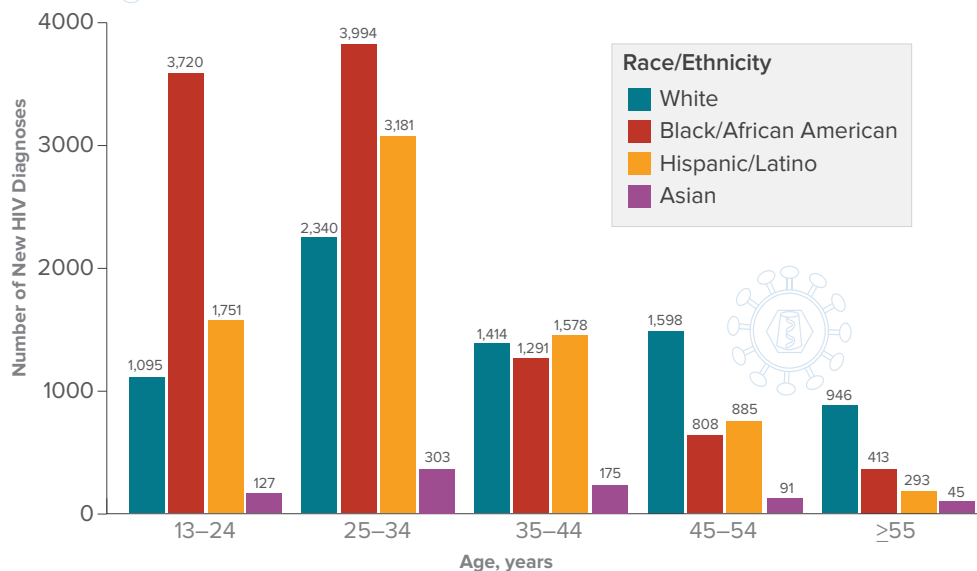
HIV and Gay and Bisexual Men

**OF THE 40,324 HIV DIAGNOSES IN THE US AND 6 DEPENDENT AREAS IN 2016:*
26,844 (67%) WERE AMONG GAY AND BISEXUAL MEN**

HIV Diagnoses Among Gay and Bisexual Men by Race/Ethnicity in the US and 6 Dependent Areas, 2016



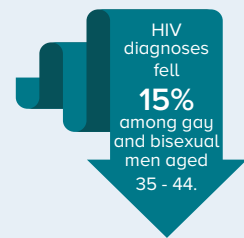
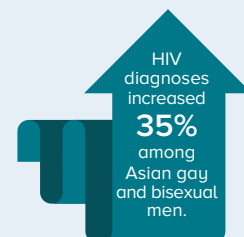
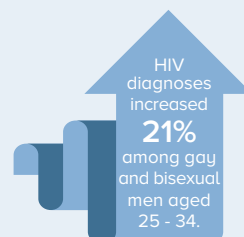
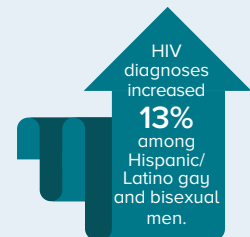
HIV Diagnoses Among Gay and Bisexual Men by Age and Race/Ethnicity in the US and 6 Dependent Areas, 2016



Subpopulations representing 2% or less of HIV diagnoses among gay and bisexual men are not reflected in this chart.

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
** Hispanics/Latinos can be of any race.

From 2011 to 2015, HIV diagnoses remained stable among all gay and bisexual men.



Around 11 million people are living with HIV in the US.* People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.



A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.

What places some gay and bisexual men at higher risk?

- More gay and bisexual men have HIV compared to any other group in the United States. Therefore, gay and bisexual men have a higher chance of having an HIV-positive partner.
- 1 in 6 gay and bisexual men with HIV are unaware they have it. People who do not know they have HIV cannot get the treatment they need and may pass the infection to others without knowing it. Among African American gay and bisexual men with HIV, a lower percentage know their status compared to HIV-positive gay and bisexual men of some other races/ethnicities.
- Most gay and bisexual men get HIV through having anal sex without condoms or medicines to prevent or treat HIV. Anal sex is the riskiest type of sex for getting or transmitting HIV.
- Gay and bisexual men are at increased risk for STDs, like syphilis, gonorrhea, and chlamydia. Having another STD can significantly increase a person's chance of getting or transmitting HIV.
- Stigma, homophobia, and discrimination put gay and bisexual men of all races/ethnicities at risk for many health issues and may affect whether they are able to get quality health care.

How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends among gay and bisexual men.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments and community organizations by funding HIV prevention work for gay and bisexual men and providing technical assistance.
- Supporting community organizations that can increase access to HIV testing and care and other services for gay and bisexual men.
- Promoting testing, prevention, and treatment through *Act Against AIDS* campaigns that feature gay and bisexual men, such as *Start Talking. Stop HIV. Doing It*, and *HIV Treatment Works*.

* In 50 states and District of Columbia.

Reduce Your Risk



Not having sex



Using condoms



Not sharing syringes



Taking medicine to prevent or treat HIV



HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit gettested.cdc.gov to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

AT THE END OF 2015,
AN ESTIMATED
632,300

GAY AND BISEXUAL MEN
HAD HIV.†

5 in 6
KNEW THEY HAD THE VIRUS.

FOR EVERY 100 GAY AND BISEXUAL MEN WITH HIV IN 2015:†







For More Information

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

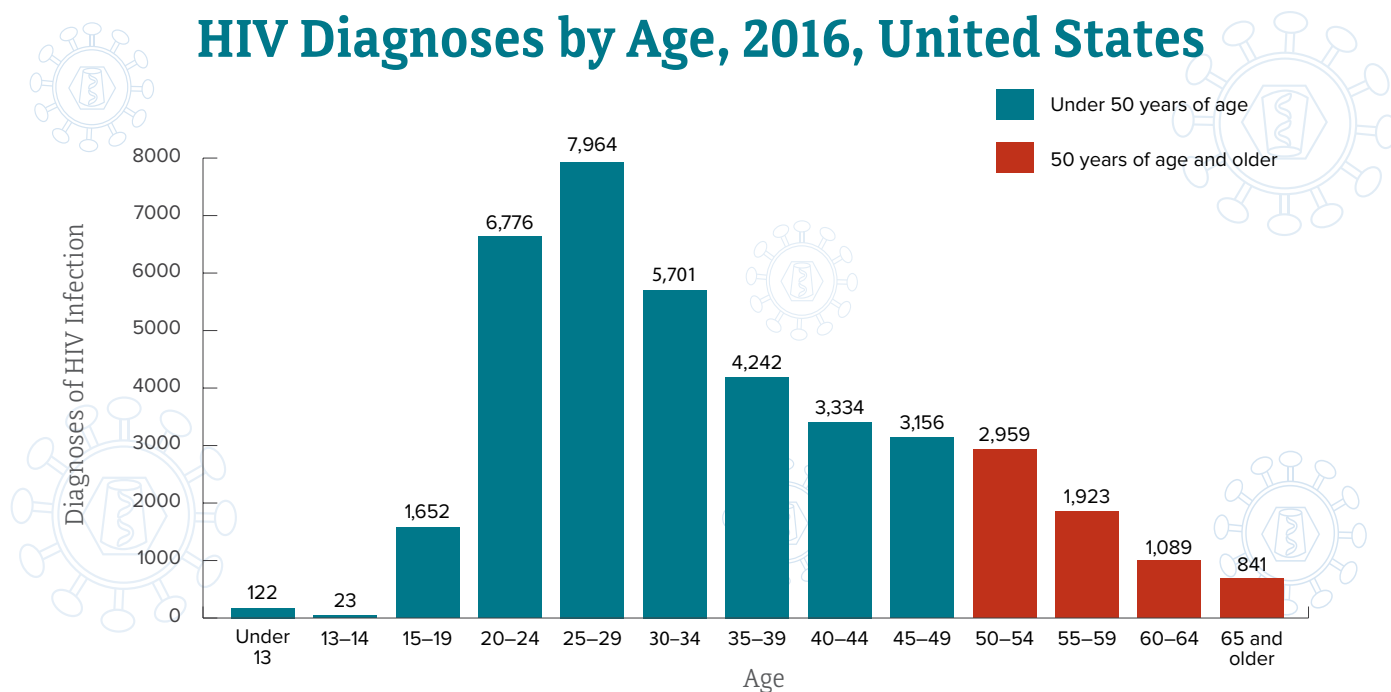
HIV and Older Americans

OF THE 39,782 HIV DIAGNOSES IN THE US IN 2016:
6,812 (17%) WERE AGED 50 AND OLDER.

Among people aged 50 and older who received an HIV diagnosis:

-  49% were gay and bisexual men
-  15% were heterosexual men
-  24% were heterosexual women
-  12% were people who inject drugs*

HIV Diagnoses by Age, 2016, United States



From 2011 to 2015 HIV diagnoses among all people aged 50 and older decreased by 7%.

* People who inject drugs includes infections attributed to injection drug use and other sexual risk factors.

Around 1.1 million people are living with HIV in the US. People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.



A person living with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to a negative partner.

Aging with HIV infection presents special challenges for preventing other diseases because both age and HIV increase risk for heart disease, bone loss, and certain cancers.



Unfortunately, thousands of Americans still die each year from HIV. In 2015, 2,749 people aged 55 and older died from HIV disease.

Why are older Americans at risk?

- Older people in the United States are more likely than younger people to have AIDS at the time of diagnosis, which means they start treatment late and may suffer more immune-system damage.
- Older people have the same HIV risk factors as younger people, but may not be as knowledgeable about prevention.
- Although they visit their doctors more often, older people are less likely than younger people to talk about their sexual or drug use behaviors with their doctors.

How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends among older Americans.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments, education agencies, and community organizations by funding HIV prevention work for older Americans and providing technical assistance.
- Promoting testing, prevention and treatment through campaigns like *Act Against AIDS*.

AT THE END OF 2015,
AN ESTIMATED
298,200
PEOPLE OVER 55
HAD HIV.

95%
KNEW THEY HAD HIV

FOR EVERY 100 PEOPLE
AGED 55 AND OLDER
LIVING WITH HIV
IN THE US IN 2015:



Reduce Your Risk



Not having sex



Using condoms



Not sharing syringes



Taking medicine to prevent or treat HIV

HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit gettested.cdc.gov to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

For More Information

Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

HIV and Youth

OF THE 39,782 HIV DIAGNOSES IN 2016:

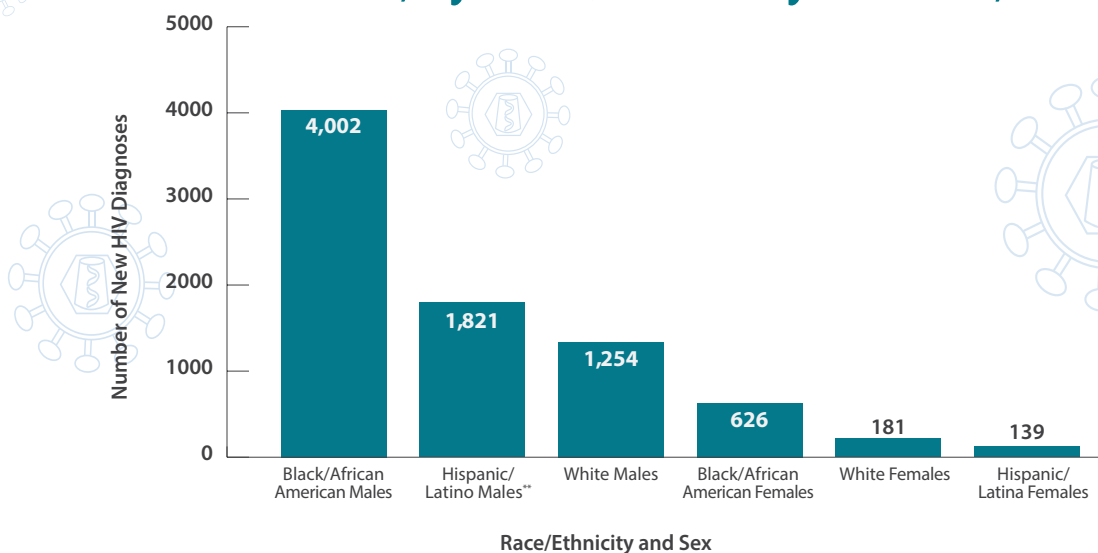
8,451 WERE AMONG YOUTH* AGED 13 - 24

6,848 WERE AMONG YOUNG GAY AND BISEXUAL MEN

4 OUT OF 5 YOUTH DIAGNOSED WITH HIV WERE AGED 20 - 24

21% OF ALL NEW HIV DIAGNOSES IN THE US WERE AMONG YOUTH

HIV Diagnoses Among Youth in the United States, by Race/Ethnicity and Sex, 2016



Subpopulations representing 2% or less of all people who received an HIV diagnosis in 2016 are not represented in this chart.

From 2011 to 2015, HIV diagnoses among youth remained stable overall.***

remained stable among young African American and white gay and bisexual men

increased 19% among young Hispanic/Latino gay and bisexual men

fell 25% among young women

remained stable among young people who inject drugs

* Unless otherwise noted, people aged 13 to 24 are referred to as youth or young in this fact sheet.

** Hispanics/Latinos can be of any race.

*** From 2010 to 2015, new HIV infections (incidence) fell 24% among youth. Incidence data includes the number of people who get HIV (both diagnosed and undiagnosed) each year. Diagnosis data includes the number of people receiving an HIV diagnosis each year (regardless of the year they were infected). In general, any difference between an incidence trend and a diagnosis trend can be attributed to HIV testing and diagnosis.



Around 1.1 million people are living with HIV in the US. People living with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable. A person living with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.



Unfortunately, thousands of Americans still die each year from HIV. In 2015, 100 youth aged 15 to 24 died from HIV disease.

What places some young people at higher risk?

- Many students are not getting the sexual health education they need, and sex education is not starting early enough.
- Certain risk behaviors put youth at higher risk for HIV, including low HIV testing rates, substance use, low rates of condom use, and multiple sex partners. Research has also shown that young gay and bisexual men who have sex with older partners are at a greater risk for HIV infection.
- Youth aged 20 to 24, especially youth of color, have some of the highest STD rates. Having another STD can significantly increase a person's chance of getting or transmitting HIV.
- Many young people avoid talking about HIV with their sex partners.
- Stigma, fear, homophobia, isolation, and lack of support may also place many youth at higher risk for HIV.

How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends among youth.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments, education agencies, and community organizations by funding HIV prevention work for youth and providing technical assistance.
- Promoting testing, prevention, and treatment through campaigns like *Act Against AIDS*.

Visit www.cdc.gov/hiv and www.cdc.gov/healthyouth for more information about CDC's HIV prevention activities among youth.

Reduce Your Risk



Not having sex



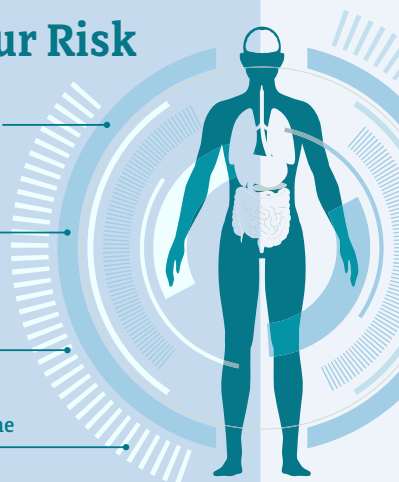
Using condoms



Not sharing needles



Taking medicine to prevent or treat HIV



HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing needles with a person who is living with HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit gettested.cdc.gov to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you are living with HIV, start treatment as soon as possible to stay healthy and help protect your partners.

AT THE END OF 2015,
AN ESTIMATED
60,300
YOUTH WERE
LIVING WITH HIV.

1 in 2
DIDN'T KNOW THEY WERE
LIVING WITH THE VIRUS

**FOR EVERY 100
YOUNG PEOPLE
LIVING WITH HIV IN 2014:**



For More Information

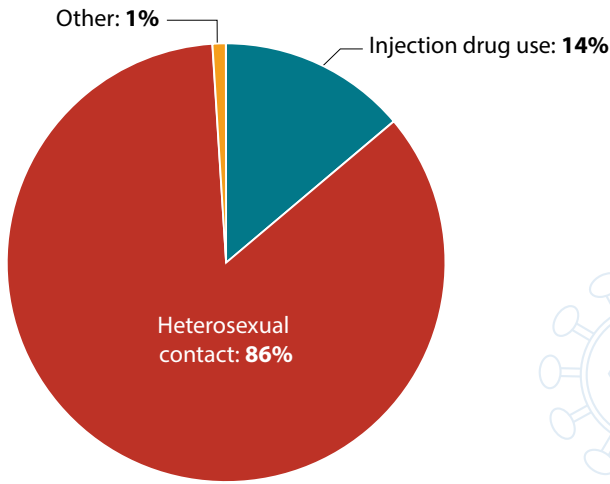
Call 1-800-CDC-INFO (232-4636)
Visit www.cdc.gov/hiv

HIV and Women

OF THE 38,739 NEW HIV DIAGNOSES IN THE US AND DEPENDENT AREAS* IN 2017, **7,401 (19%) WERE AMONG WOMEN.**

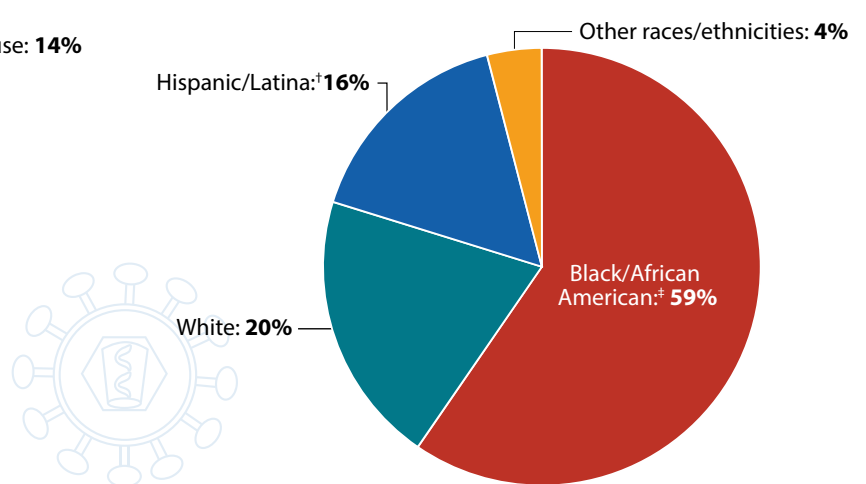
New HIV Diagnoses Among Women in the US and Dependent Areas in 2017

By Transmission Category



Total may not equal 100% due to rounding.

By Race/Ethnicity



Total may not equal 100% due to rounding.

From 2010 to 2016, HIV diagnoses decreased 21% among women overall.** But trends varied for different groups of women.

Women overall: down 21%

Black/African American: down 25%

Hispanic/Latina: down 20%

White: remained stable

Women by age:

- 13 to 24: down 32%**
- 25 to 34: down 13%**
- 35 to 44: down 27%**
- 45 to 54: down 27%**
- 55 and older: remained stable**

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
 † Hispanics/Latinas can be of any race.
 ‡ Black refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean, and South and Latin America. African American is a term often used for Americans of African descent with ancestry in North America. Individuals may self-identify as either, both, or choose another identity altogether.
 ** In 50 states and District of Columbia.



Around 1.1 million people are living with HIV in the US.** People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.



A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.

What places some women at higher risk?

- 1 in 9 women with HIV are unaware they have it. People who do not know they have HIV cannot take advantage of HIV care and treatment and may unknowingly pass HIV to others.
- Sexually transmitted diseases, like gonorrhea and syphilis, may place some women at higher risk for HIV.
- Some women don't know their male partner's risk factors for HIV (such as injection drug use or having sex with men) and may not use condoms or medicines to prevent HIV.
- Women have a higher risk for getting HIV during vaginal or anal sex than their sex partners. The riskiest behavior for getting HIV is receptive anal sex.
- Women who have been sexually abused may be more likely to engage in risky behaviors like exchanging sex for drugs, having multiple sex partners, or having sex without a condom.

How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends among women.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments and community organizations by funding HIV prevention work for women and providing technical assistance.
- Supporting community organizations that can increase access to HIV testing and care and other services for women.
- Promoting testing, prevention, and treatment through campaigns like *Act Against AIDS*.

AT THE END OF 2016,
AN ESTIMATED
258,000

**WOMEN
HAD HIV.****

8 in 9

KNEW THEY HAD THE VIRUS.

**FOR EVERY 100 WOMEN
WITH HIV IN 2015:****



Reduce Your Risk



Not having sex



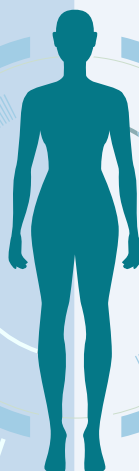
Using
condoms



Not sharing
syringes



Taking medicine
to prevent
or treat HIV



HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.

It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit gettested.cdc.gov to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

For More Information

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Visit www.cdc.gov/hiv

HIV and Pregnant Women, Infants, and Children



HIV can be passed from mother to child anytime during pregnancy, childbirth, and breastfeeding. This is called *perinatal* transmission.



BUT THERE IS GOOD NEWS:

For a woman with HIV, the risk of transmitting HIV to her baby can be **1% OR LESS** if she:



Takes HIV medicine daily as prescribed throughout pregnancy and childbirth.



Gives HIV medicine to her baby for 4-6 weeks after giving birth.



Does NOT breastfeed or pre-chew her baby's food.



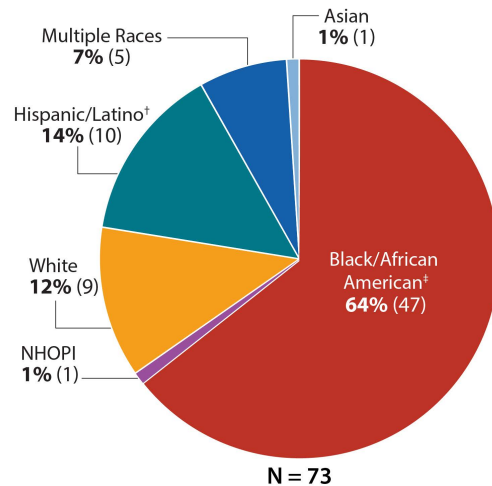
If you are pregnant or planning to get pregnant, **get tested for HIV** as soon as possible. If you have HIV, the sooner you start treatment the better—for your health and your baby's health and to prevent transmitting HIV to your sexual partner.

73 diagnoses of perinatal HIV in the US in 2017*

From 2012 to 2016, perinatal diagnoses: **decreased 41%**



Diagnoses of Perinatal HIV Infections in the US and Dependent Areas by Race/Ethnicity, 2017



* Unless otherwise noted, the term *United States* (US) includes the 50 states, the District of Columbia, and the 6 dependent areas of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

† Hispanics/Latinos can be of any race.

‡ *Black* refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean, and South and Latin America. *African American* is a term often used for Americans of African descent with ancestry in North America. Individuals may self-identify as either, both, or choose another identity altogether.



Women who are pregnant or trying to get pregnant should encourage their partner to get tested for HIV also. If either partner has HIV, that partner should take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.



A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.

HIV-negative women who have a partner with HIV should ask their doctor about taking HIV medicine daily, called pre-exposure prophylaxis (PrEP), to protect themselves and their baby.

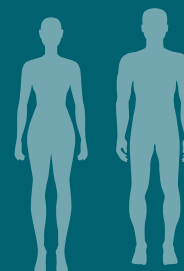
Why are pregnant women and their babies at risk?

- Preconception care and family planning services are often not provided in HIV care settings.
- Women with HIV may not know they are pregnant, how to prevent or safely plan a pregnancy, or what they can do to reduce the risk of transmitting HIV to their baby.
- The risk of transmitting HIV to the baby is much higher if the mother does not stay on HIV treatment throughout pregnancy and childbirth, or if HIV medicine is not provided to her baby. The risk is also higher if she gets HIV during pregnancy.
- Social and economic factors, especially poverty, may make it harder for some women with HIV to access health care and stay on treatment.

How is CDC making a difference?

- CDC created a framework (www.cdc.gov/hiv/group/gender/pregnantwomen/emct.html) to help federal agencies and other groups lower the rate of perinatal HIV transmission to less than 1% and reduce the number of cases of perinatal HIV to less than one per 100,000 live births.
- CDC helps lead the Elimination of Mother-to-Child HIV Transmission Stakeholders Group, a group that develops and implements strategies to advance the elimination of perinatal HIV.
- CDC collaborated with and funded partners to develop a continuous quality improvement method that helps local health systems address missed prevention and treatment opportunities for pregnant women with HIV.
- CDC funds perinatal HIV prevention through Integrated Human Immunodeficiency Virus Surveillance and Prevention Programs for Health Departments (www.cdc.gov/hiv/funding/announcements/ps18-1802), and promotes HIV testing and treatment for pregnant women.

By the end of 2016 in the US, **11,915 people** were living with HIV they got through **perinatal transmission**.



1,814 of them were **children** under the age of 13.



Reduce Your Risk



Not having sex



Using condoms



Not sharing syringes



Taking medicine to prevent or treat HIV



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For More Information

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HIV and Transgender People

HIV Diagnoses in the US, 2009-2014

2,351 TRANSGENDER PEOPLE RECEIVED AN HIV DIAGNOSIS. OF THESE:

**84% WERE
TRANSGENDER
WOMEN**

**15% WERE
TRANSGENDER MEN***

ABOUT HALF LIVED IN THE SOUTH



Transgender: people whose gender identity or expression is different from their sex assigned at birth.



Gender identity: person's internal understanding of their own gender.



Gender expression: person's outward presentation of their gender (example, how they dress).

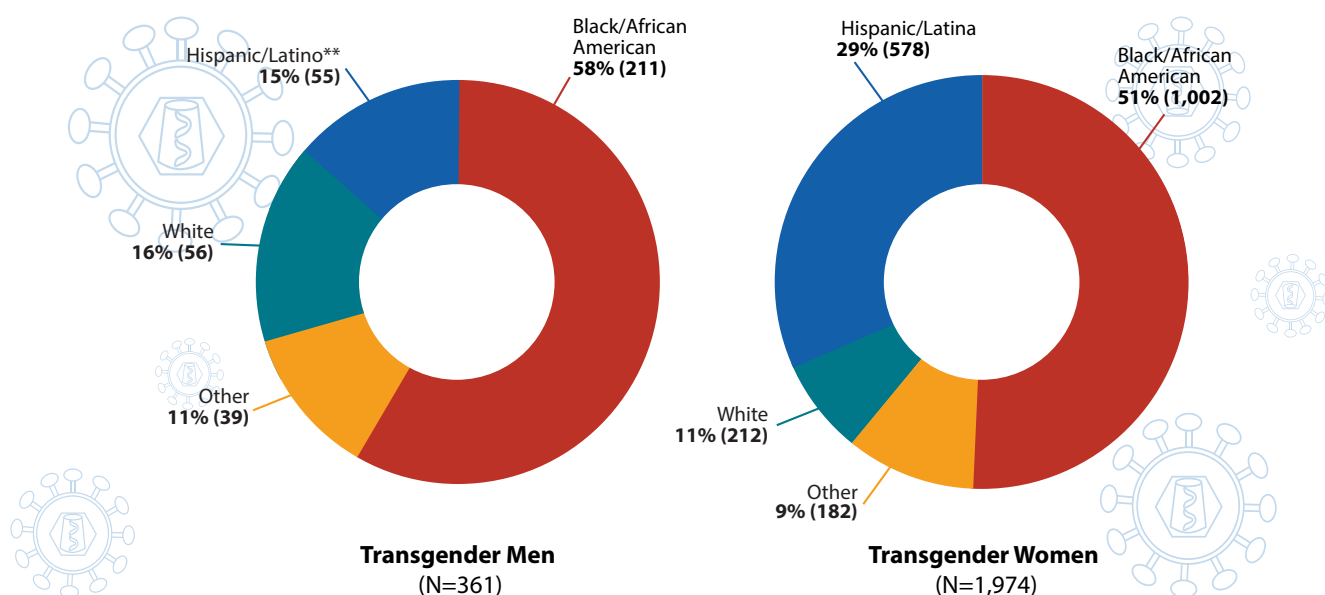


Transgender women: people who were assigned the male sex at birth but identify as women.



Transgender men: people who were assigned the female sex at birth but identify as men.

HIV Diagnoses Among Transgender People in the United States by Race/Ethnicity, 2009-2014



* Less than 1% had another gender identity

** Hispanics/Latinos can be of any race

Around 1.1 million people are living with HIV in the US. People living with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable. A person living with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of sexually transmitting HIV to HIV-negative partners.

Why are transgender people at higher risk?

- Some things that may put transgender people at higher risk for getting or transmitting HIV include multiple sexual partners, anal or vaginal sex without condoms or medicines to prevent or treat HIV, and sharing syringes to inject hormones or drugs.
- Many transgender people face stigma, discrimination, social rejection, and exclusion. These factors may affect their well-being and put them at increased risk for HIV.
- HIV prevention programs designed for other at-risk groups may not address all the needs of transgender people.
- When health care providers are not sensitive to transgender issues, this can be a barrier for transgender people living with HIV and looking for treatment and care.
- Current HIV testing programs may not be enough to reach transgender women and men.

How is CDC making a difference?

- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments and community organizations by funding HIV prevention work for transgender people and providing technical assistance.
- Helping health care providers improve care for transgender people living with HIV.
- Promoting testing, prevention, and treatment through campaigns like *Act Against AIDS*.

Visit www.cdc.gov/hiv for more information about CDC's HIV prevention activities among transgender people.

According to current estimates, around a quarter (22-28%) of transgender women are living with HIV.

An estimated 56% of black transgender women were living with HIV—the highest percentage among all transgender women.

Reduce Your Risk



Not having sex



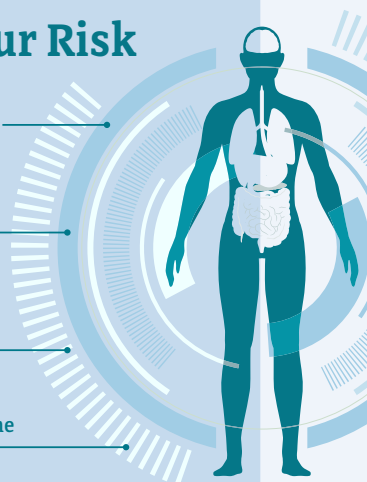
Using condoms



Not sharing needles



Taking medicine to prevent or treat HIV




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TEXAS
Health and Human
Services

Texas Department of State
Health Services

2016 HIV Surveillance Data among PLWH who are Transgender

Jie Deng
Epidemiology and Supplemental Projects Group
TB/HIV/STD Epidemiology and Surveillance Branch
April, 2017

Introduction

- **Preliminary** HIV surveillance data overview among PLWH who are transgender
- Data update regarding gender identity in HIV surveillance system is still in progress
- Since this data is fairly new, it's important to remember that we are likely undercounting the true number.
The numbers in this slide set are provisional



Overview

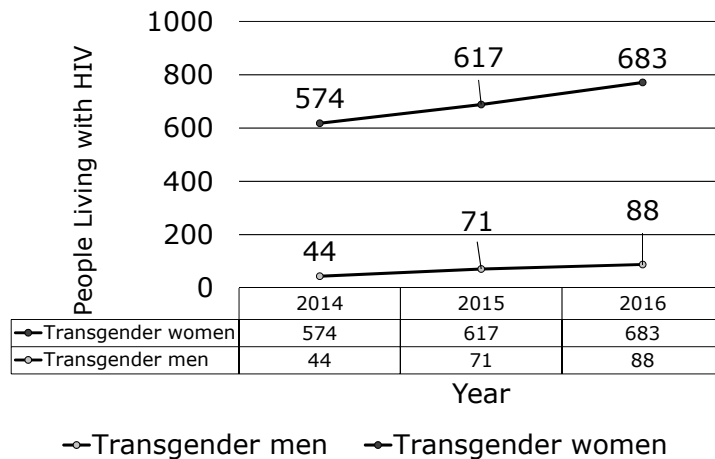
New HIV diagnoses, People Living with HIV, and Deaths among PLWH who are Transgender in Texas

- In 2016, there were 683 Transgender Women and 88 Transgender Men living with HIV in Texas. That year, 73 Transgender Women and 13 Transgender Men were newly diagnosed with HIV.
- 10 Transgender Women living with HIV died in 2014.

3/25/2019

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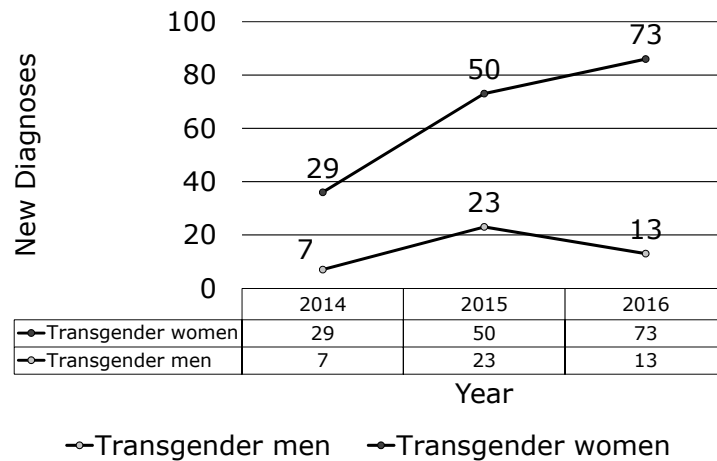
People Living with HIV who are Transgender



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New HIV Diagnoses among PLWH who are Transgender



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Deaths among People Living with HIV who are Transgender

Death year	Current Gender	
	Transgender Men	Transgender Women
2014	0	10

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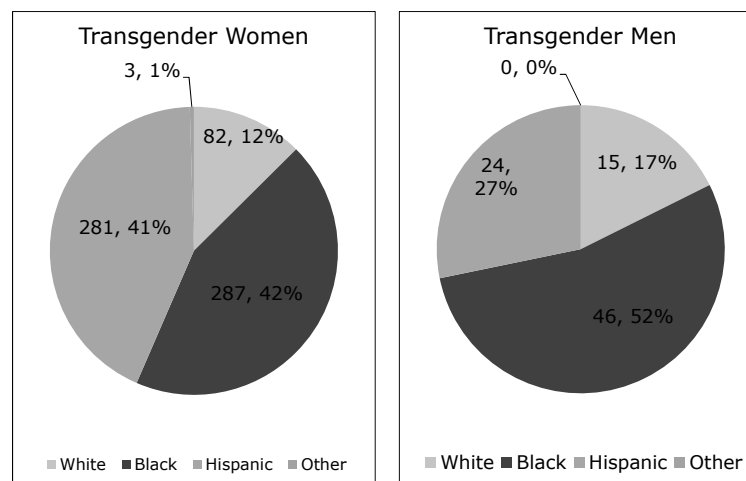
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HIV Prevalence in Texas among People who are Transgender

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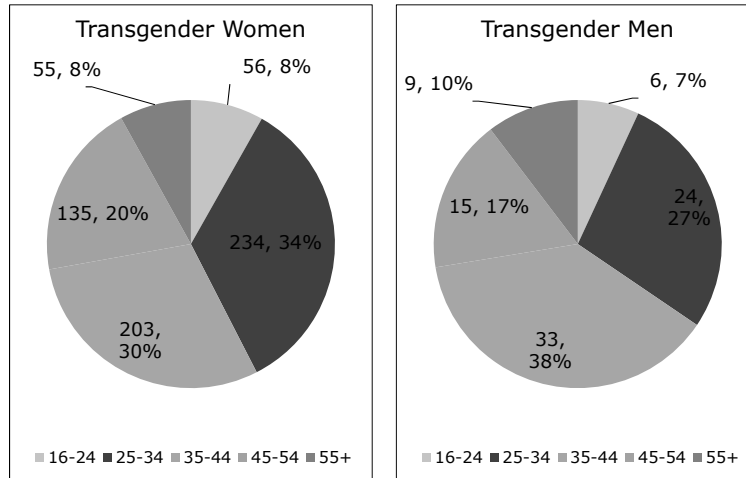
PLWH who are Transgender by Race/Ethnicity, 2016



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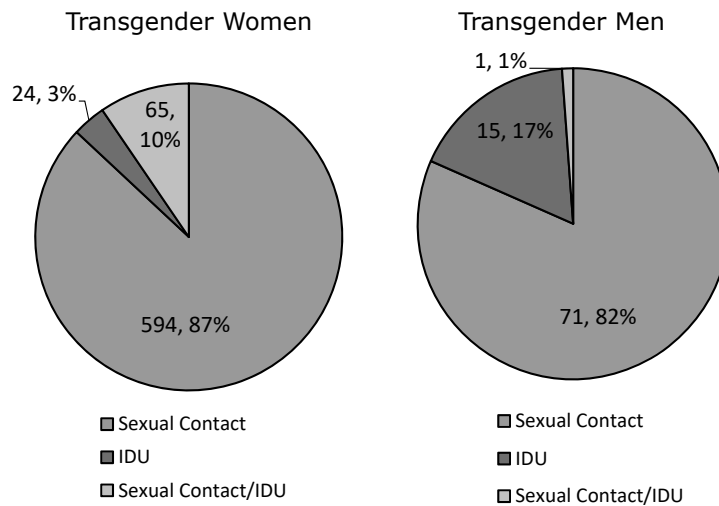
PLWH who are Transgender by Age, 2016



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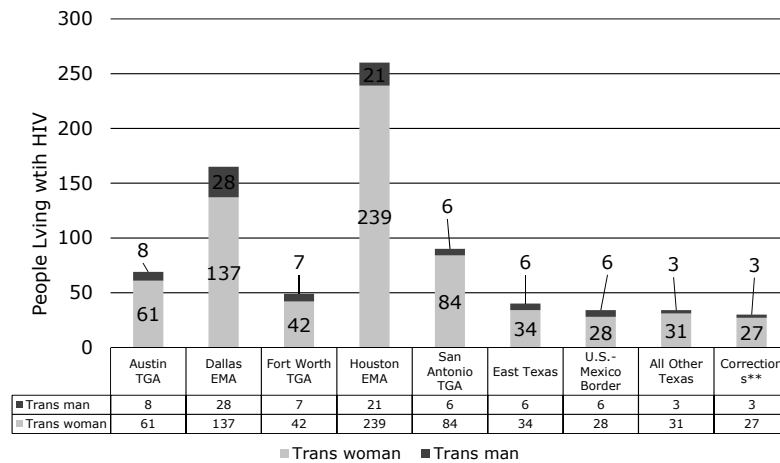
PLWH among Transgender by Mode of Transmission, 2016



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PLWH among Transgender by EMA/TGA, 2016



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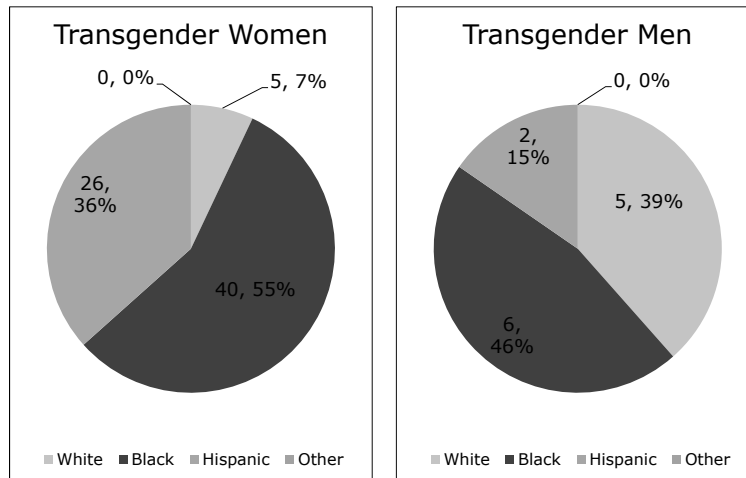
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New HIV Diagnoses among PLWH who are Transgender

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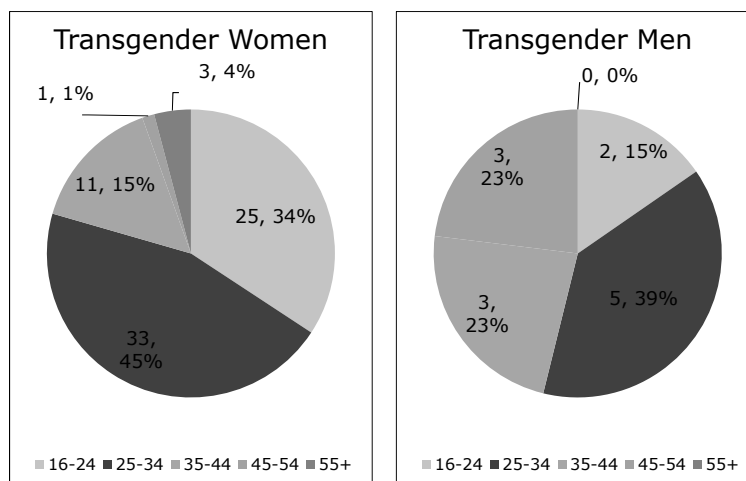
New HIV Diagnoses among Trans by Race/Ethnicity, 2016



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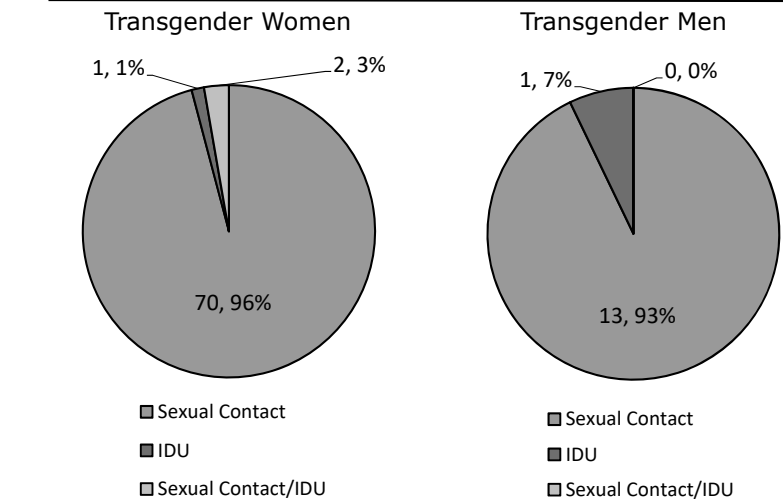
New HIV Diagnoses among Trans by Age, 2016



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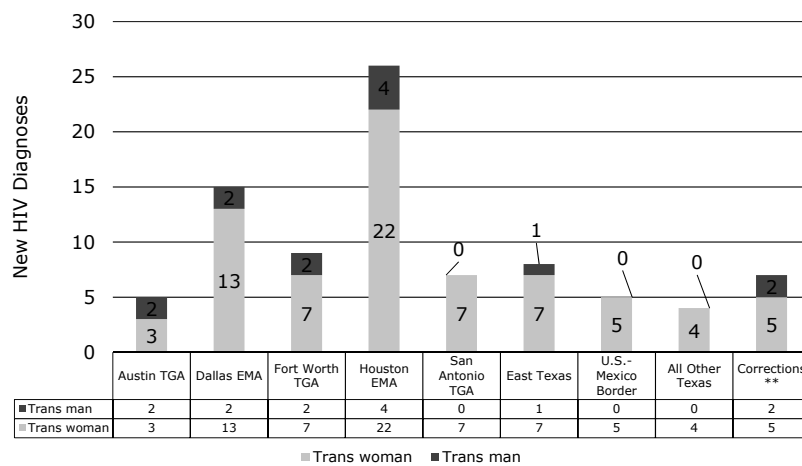
New HIV Diagnoses among Trans by Mode of Transmission, 2016



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New HIV Diagnoses among Trans by EMA/TGA*, 2016



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Stage 3 HIV (AIDS)

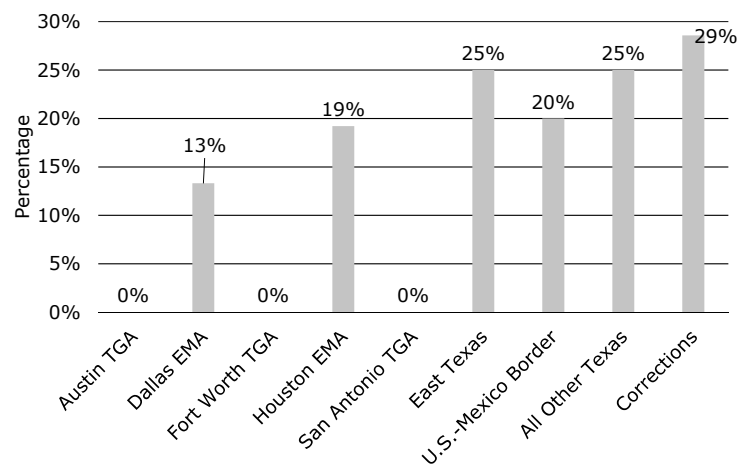
HIV infection, stage 3 (AIDS), defined by Centers for Disease Control and Prevention*:

- CD4 count <200 cells/ μ L
- CD4 percentage of total lymphocytes <14%
- Documentation of an AIDS-defining condition

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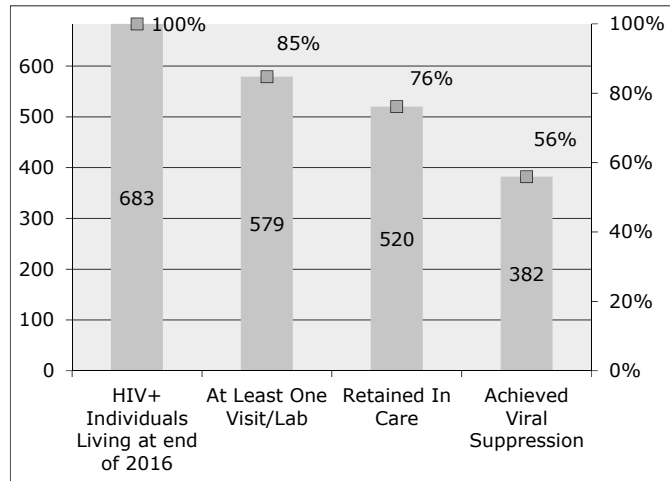
Late Diagnoses* as Percentage of Total HIV Diagnoses among Trans 2016



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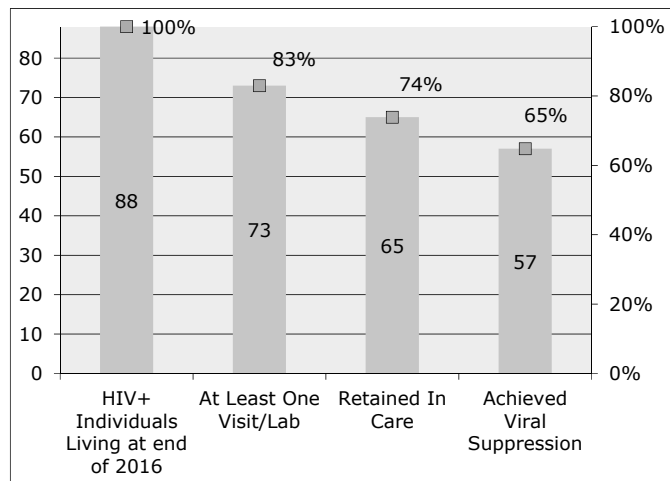
Care Continuum among Transgender Women, 2016



3/25/2019

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Care Continuum among Transgender Men, 2016



3/25/2019

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Summary

- More HIV cases among transgender women compared to transgender men;
- Black transgender men and Hispanic/Latinx transgender women were accounted for larger proportions for either new HIV cases or living cases;
- Potential shorter life expectancy among transgender people living with HIV;

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Summary

- Houston EMA and Dallas EMA had the highest numbers of transgender HIV cases;
- Proportions of late HIV diagnoses among transgender PLWH were higher in rural areas but generally lower than the statewide averages;
- Generally, the HIV treatments among transgender PLWH were better than the statewide averages.

3/25/2019

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Thank you

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3/25/2019

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