

National Black HIV/AIDS Awareness Day — February 7, 2016

February 7 is National Black HIV/AIDS Awareness Day, which is intended to raise awareness of human immunodeficiency virus (HIV) infection, which causes acquired immunodeficiency syndrome (AIDS). The observance also encourages action, such as HIV testing, to reduce the disproportionate impact of HIV/AIDS on non-Hispanic blacks/African Americans (blacks) in the United States. From 2010 to 2014, the annual HIV diagnosis rate decreased for blacks (1). However, blacks continued to account for nearly half of all HIV diagnoses each year, with most diagnoses occurring among gay and bisexual men (2).

In 2014, blacks accounted for 44% of new HIV diagnoses, with men accounting for 73% of these diagnoses (1). The annual HIV diagnosis rate for black women (30.0 per 100,000) was 18 times the rate for white women (1.7) and five times the rate for Hispanic/Latino women (6.5). Among blacks living with HIV in 2011, 85% received an HIV diagnosis, 40% were engaged in HIV care, 36% were prescribed antiretroviral therapy, and 28% were virally suppressed (3).

Additional information is available online regarding National Black HIV/AIDS Awareness Day (<http://www.cdc.gov/features/blackhivaidsawareness>) as well as blacks and HIV/AIDS (<http://www.cdc.gov/hiv/group/racial-ethnic/africanamericans/index.html>).

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Disparities in Consistent Retention in HIV Care — 11 States and the District of Columbia, 2011–2013

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In 2013, 45% of new human immunodeficiency virus (HIV) infection diagnoses occurred in non-Hispanic blacks/African Americans (blacks) (1), who represent 12% of the U.S. population.* Antiretroviral therapy (ART) improves clinical outcomes and reduces transmission of HIV, which causes acquired immunodeficiency syndrome (AIDS) (2). Racial/ethnic disparities in HIV care limit access to ART, perpetuating disparities in survival and reduced HIV transmission. National HIV Surveillance System (NHSS) data are used to monitor progress toward reaching the National HIV/AIDS Strategy

* U.S. Census Bureau. Population estimates. <http://www.census.gov/popest/data/>.

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goals to improve care among persons living with HIV and to reduce HIV-related disparities.[†] CDC used NHSS data to describe retention in HIV care over 3 years and describe differences by race/ethnicity. Among persons with HIV infection diagnosed in 2010 who were alive in December 2013, 38% of blacks with HIV infection were consistently retained in care during 2011–2013, compared with 50% of Hispanics/Latinos (Hispanics) and 49% of non-Hispanic whites (whites). Differences in consistent retention in care by race/ethnicity persisted when groups were stratified by sex or transmission category. Among blacks, 35% of males were consistently retained in care compared with 44% of females. Differences in HIV care retention by race/ethnicity were established during the first year after diagnosis. Efforts to establish early HIV care among blacks are needed to mitigate racial/ethnic disparities in HIV outcomes over time.

All states and U.S. territories report cases of HIV infections and associated demographic and clinical information to NHSS. CDC analyzed data from NHSS reported through July 2015 from 12 jurisdictions with complete laboratory reporting from January 2010–December 2013.[§] These jurisdictions accounted for 25% of HIV diagnoses reported in the United States for 2010. This analysis includes persons aged ≥ 13 years who received a diagnosis of HIV infection in 2010 and were

[†] <https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf>.

[§] District of Columbia, Illinois, Indiana, Iowa, Louisiana, Michigan, Missouri, New Hampshire, New York, North Dakota, South Carolina, and West Virginia.

Summary

What is already known on this topic?

A higher percentage of non-Hispanic blacks/African Americans (blacks) received a diagnosis of human immunodeficiency virus (HIV) infection in 2013 compared with other racial/ethnic groups in the United States. Linkage to and retention in HIV care and treatment are crucial to achieving sustained viral suppression, which can result in reduced transmission to others and improved clinical outcomes for persons living with HIV infection.

What is added by this report?

Fewer blacks were consistently retained in HIV care compared with other racial/ethnic groups, regardless of sex or transmission category; in addition, black males were less likely to be consistently retained than were black females. Lower levels of consistent retention in care among blacks were attributed to higher proportions of blacks not being retained in care for any of the 3 years during 2011–2013.

What are the implications for public health practice?

Given disparities in retention in HIV care between blacks and other racial/ethnic groups, identifying approaches to promote early linkage to and retention in care among blacks might be beneficial in mitigating racial/ethnic disparities in HIV outcomes.

alive in December 2013. Retention in HIV care, defined as having two or more CD4+ or viral load tests ≥ 3 months apart during a given calendar year, was assessed annually for 2011, 2012, and 2013. The percentage of persons retained in care for 0, 1, 2, and 3 years during 2011–2013 was determined.

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Persons retained in care for all 3 years were considered to be consistently retained in HIV care. Differences in consistent retention in care were assessed by race/ethnicity, sex, transmission category, and state of residence at diagnosis. Results were statistically adjusted for missing information on transmission category using multiple imputation (3).

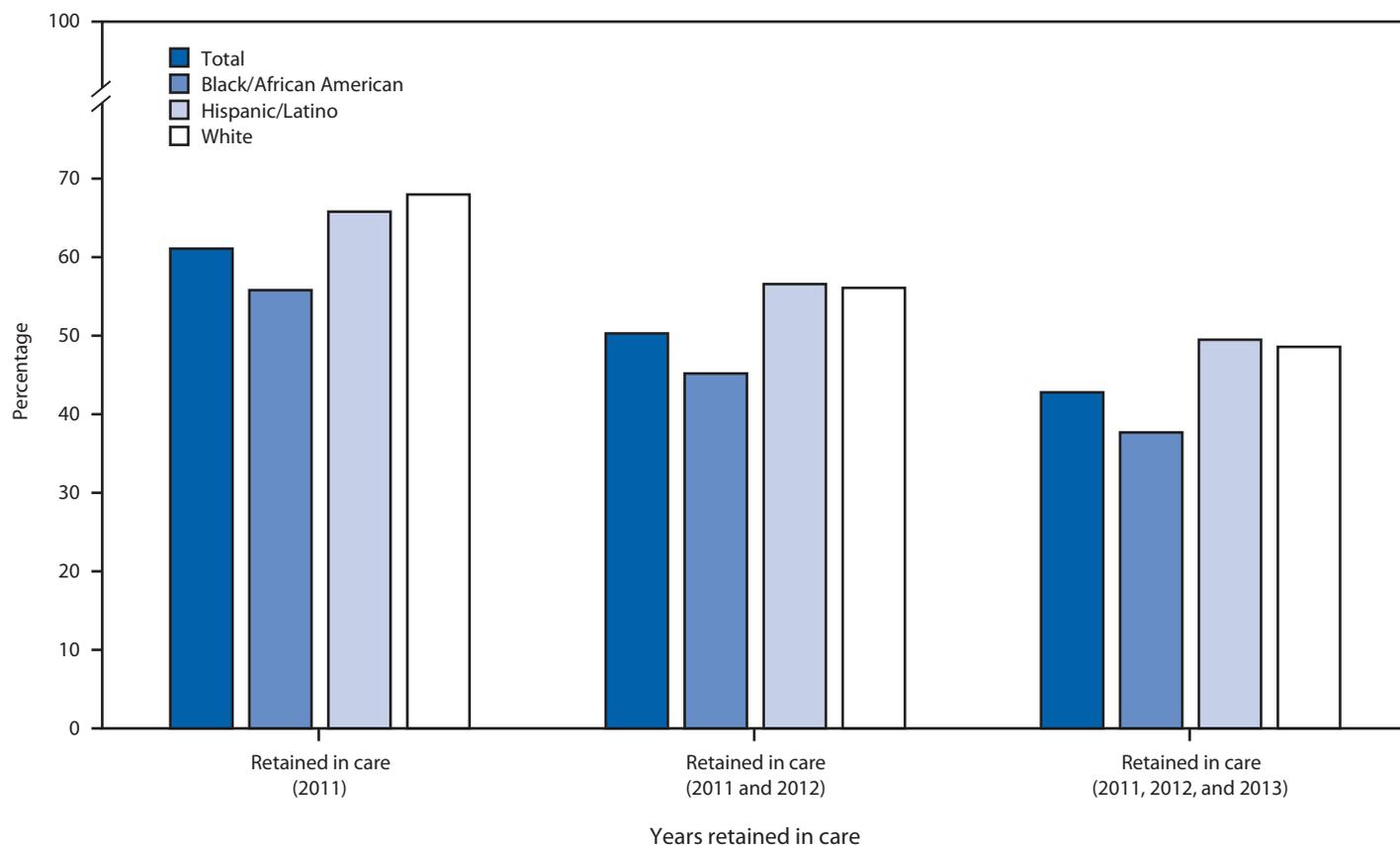
In the 12 jurisdictions, a total of 9,824 adults and adolescents received a diagnosis of HIV infection in 2010 and were alive in December 2013. Of the 9,824, 54% were black, 17% were Hispanic, and 24% were white. Overall, 61% were retained in HIV care in 2011, 50% were retained in both 2011 and 2012, and 43% were retained during 2011–2013 (Figure 1). Among persons retained in care in 2011, 82% were retained in both 2011 and 2012. Among persons retained in care during both 2011 and 2012, 85% were retained during 2011–2013. A lower proportion of blacks were retained during 2011–2013 (38%), compared with Hispanics (50%) and whites (49%).

Differences in consistent retention in care by race/ethnicity persisted when stratified by sex or transmission category, with a lower proportion of blacks retained in HIV care for all 3 years, compared with other groups (Table). Further, retention in care for all 3 years was lower among blacks in seven of the 12 jurisdictions (District of Columbia, Illinois, Iowa, Michigan, Missouri, New Hampshire, and New York).

A smaller percentage of black males, who accounted for more than two thirds of blacks with HIV diagnosed in 2010, were consistently retained in care during 2011–2013 compared with black females (35% versus 44%, respectively) (Table). Among blacks, consistent retention in care was highest for persons with infection attributable to heterosexual contact, and among these persons, consistent retention in care was higher for females (45%) than for males (37%).

Overall, 43% of all persons included in the analysis were retained in HIV care for all 3 years during 2011–2013.

FIGURE 1. Percentage of persons aged ≥ 13 years with human immunodeficiency virus (HIV) infection diagnosed in 2010 who were alive in December 2013 and who were retained in HIV medical care* during 2011–2013, by race/ethnicity and years retained in care — National HIV Surveillance System, 11 states and the District of Columbia†



* Retention in HIV care was defined as having two or more CD4+ or viral load tests ≥ 3 months apart during a given calendar year and was assessed annually for 2011, 2012, and 2013.

† Only jurisdictions with complete laboratory reporting were included in the analysis: District of Columbia, Illinois, Indiana, Iowa, Louisiana, Michigan, Missouri, New Hampshire, New York, North Dakota, South Carolina, and West Virginia.

TABLE. Consistent retention* in human immunodeficiency virus (HIV) medical care among persons aged ≥13 years with HIV infection diagnosed in 2010 who were alive in December 2013, by race/ethnicity† and selected characteristics — National HIV Surveillance System, 11 states and the District of Columbia

Characteristic	Race/Ethnicity							
	Overall		Black/African American		Hispanic/Latino		White	
	Total	Consistently retained	Total	Consistently retained	Total	Consistently retained	Total	Consistently retained
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Total	9,824 (100.0)	4,201 (42.8)	5,286 (100.0)	1,993 (37.7)	1,682 (100.0)	833 (49.5)	2,358 (100.0)	1,145 (48.6)
Sex								
Male	7,566 (77.0)	3,173 (41.9)	3,712 (70.2)	1,297 (34.9)	1,356 (80.6)	673 (49.6)	2,094 (88.8)	1,024 (48.9)
Female	2,258 (23.0)	1,028 (45.5)	1,574 (29.8)	696 (44.2)	326 (19.4)	160 (49.1)	264 (11.2)	121 (45.8)
Transmission category								
Male-to-male sexual contact	5,953 (60.6)	2,530 (42.5)	2,732 (51.7)	956 (35.0)	1,056 (62.8)	526 (49.8)	1,844 (78.2)	903 (49.0)
Male-to-male sexual contact and injection drug use	285 (2.9)	110 (38.6)	111 (2.1)	29 (26.3)	50 (3.0)	22 (44.0)	103 (4.4)	51 (49.8)
Injection drug use, males	474 (4.8)	181 (38.2)	279 (5.3)	91 (32.6)	114 (6.8)	53 (46.5)	66 (2.8)	30 (45.5)
Injection drug use, females	332 (3.4)	146 (44.0)	210 (4.0)	85 (40.5)	43 (2.6)	24 (55.8)	67 (2.8)	28 (41.8)
Heterosexual contact, males	843 (8.6)	348 (41.3)	584 (11.0)	218 (37.3)	134 (8.0)	71 (53.0)	78 (3.3)	39 (50.0)
Heterosexual contact, females	1,918 (19.5)	879 (45.8)	1,359 (25.7)	610 (44.9)	282 (16.8)	135 (47.9)	197 (8.4)	92 (46.7)
Other	20 (0.2)	7 (35)	12 (0.2)	4 (33.3)	3 (0.2)	2 (66.7)	3 (0.1)	1 (33.3)
Jurisdiction								
District of Columbia	794 (8.1)	278 (35.0)	620 (11.7)	207 (33.4)	52 (3.1)	22 (42.3)	103 (4.4)	46 (44.7)
Illinois	1,570 (16.0)	421 (26.8)	806 (15.2)	179 (22.2)	280 (16.6)	99 (35.4)	372 (15.8)	102 (27.4)
Indiana	444 (4.5)	184 (41.4)	200 (3.8)	76 (38.0)	40 (2.4)	14 (35.0)	185 (7.8)	87 (47.0)
Iowa	102 (1.0)	51 (50.0)	23 (0.4)	10 (43.5)	10 (0.6)	5 (50.0)	60 (2.5)	32 (53.3)
Louisiana	1,027 (10.5)	387 (37.7)	755 (14.3)	262 (34.7)	36 (2.1)	10 (27.8)	210 (8.9)	107 (51.0)
Michigan	723 (7.4)	292 (40.4)	438 (8.3)	152 (34.7)	43 (2.6)	19 (44.2)	216 (9.2)	109 (50.5)
Missouri	543 (5.5)	193 (35.5)	272 (5.1)	68 (25.0)	29 (1.7)	11 (37.9)	221 (9.4)	104 (47.1)
New Hampshire	50 (0.5)	30 (60.0)	2 (0.0)	1 (50.0)	3 (0.2)	2 (66.7)	40 (1.7)	24 (60.0)
New York	3,759 (38.3)	1,997 (53.1)	1,613 (30.5)	788 (48.9)	1,147 (68.2)	640 (55.8)	756 (32.1)	435 (57.5)
North Dakota	12 (0.1)	6 (50.0)	3 (0.1)	1 (33.3)	3 (0.2)	1 (33.3)	5 (0.2)	4 (80.0)
South Carolina	725 (7.4)	343 (47.3)	542 (10.3)	245 (45.2)	33 (2.0)	10 (30.3)	136 (5.8)	80 (58.8)
West Virginia	75 (0.8)	19 (25.3)	12 (0.2)	4 (33.3)	6 (0.4)	0 (0.0)	54 (2.3)	15 (27.8)

* Defined as retained in HIV care each year during 2011–2013. Retention in HIV care was defined as having two or more CD4+ or viral load tests ≥3 months apart during a given calendar year.

† Because the estimated totals were calculated independently of the corresponding values for each population group, the individual values might not sum to the totals.

Nineteen percent were retained 2 of the 3 years; 14% were retained 1 of the 3 years, and 25% were not retained in any of the 3 years (Figure 2). A larger proportion of blacks (28%), compared with Hispanics (23%) and whites (19%), were not retained in care during any of the 3 years.

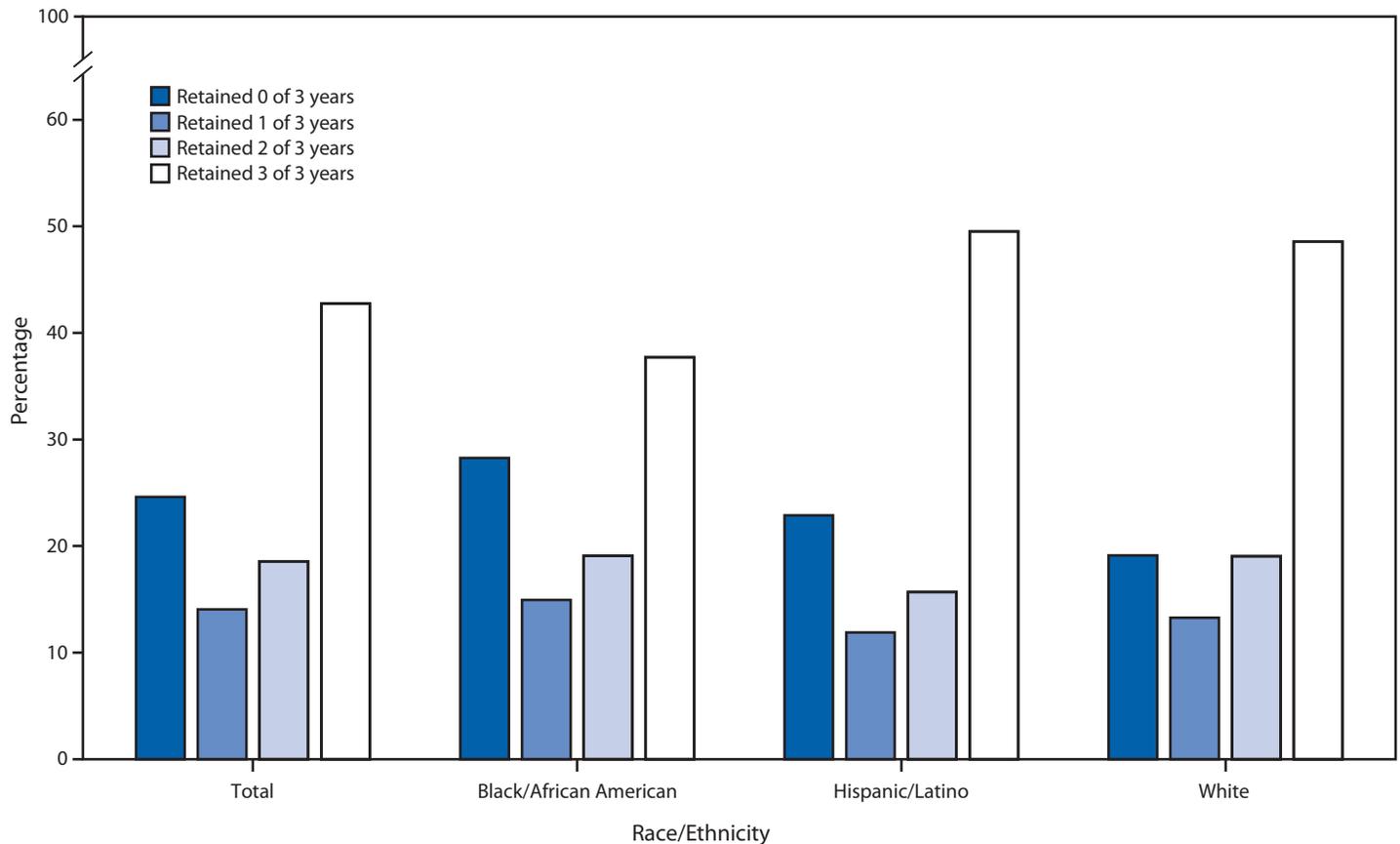
Discussion

A substantial percentage of persons with HIV infection (39%) were not retained in care in the year after their diagnosis. However, among persons retained during earlier years after diagnosis, the proportion not retained during subsequent years was low (18% in 2012 and 15% in 2013, respectively). Fewer blacks were retained in HIV care compared with other racial/ethnic groups. These findings are consistent with previous reports on racial/ethnic differences in HIV care engagement

(4) and demonstrate that these disparities remain over multiple years. The racial/ethnic differences in HIV care retention are established during the first year after diagnosis, underscoring the importance of early engagement in care to reduce disparities in sustained retention in care and thus improve the resulting outcomes (e.g., initiation of treatment and viral suppression).

Retention in care facilitates ART adherence and early detection of comorbidities, which can result in improved survival and reduced transmission of infection to others (2,5). Barriers to retention in care, such as lack of health insurance, limited access to health services, and stigma, are particularly prevalent among blacks (6). Continuing to identify barriers to HIV care engagement, including those leading to prolonged lack of retention in care, can inform development of effective interventions to improve HIV care engagement among blacks (7).

FIGURE 2. Percentage of persons aged ≥ 13 years with human immunodeficiency virus (HIV) infection diagnosed in 2010 who were alive in December 2013 and who were retained in HIV medical care* for 0, 1, 2, or 3 out of 3 years, by race/ethnicity — National HIV Surveillance System, 11 states and the District of Columbia†



* Retention in HIV care was defined as having two or more CD4+ or viral load tests ≥ 3 months apart during a given calendar year and was assessed annually for 2011, 2012, and 2013.

† Only jurisdictions with complete laboratory reporting were included in the analysis: District of Columbia, Illinois, Indiana, Iowa, Louisiana, Michigan, Missouri, New Hampshire, New York, North Dakota, South Carolina, and West Virginia.

Developing such interventions might narrow racial/ethnic disparities in clinical outcomes.

The findings in this report are subject to at least four limitations. First, HIV surveillance data do not include markers of socioeconomic status (e.g., health insurance status, annual household income, or education), which could help explain observed disparities in HIV care engagement by racial/ethnic groups. Second, analyses were restricted to 12 jurisdictions with complete laboratory reporting during the entire analysis period; these 12 jurisdictions might not be representative of all persons living with diagnosed HIV infection. Third, this analysis was limited to persons with HIV infection diagnosed during a 1-year period; for this reason, estimates are different from those previously published (4). Finally, these multiyear estimates of retention in HIV care might be artificially lower if persons moved to a jurisdiction with incomplete laboratory reporting after receiving an HIV diagnosis; however, a previous

analysis of HIV surveillance data concluded that interstate migration is relatively uncommon.¶

Focusing HIV prevention and care efforts on early diagnosis of HIV infection and early establishment of HIV care among blacks might be beneficial in reducing racial/ethnic disparities in HIV outcomes. Through partnerships with federal, state, and local health agencies, CDC is pursuing high-impact prevention strategies to address the principal goals of the National HIV/AIDS Strategy to increase access to care and reduce disparities in HIV outcomes.** CDC supports projects that aim to reduce the proportion of undiagnosed infections in the United States, improve linkage to and retention in care, and reduce HIV-related morbidity and mortality across all racial/

¶ Espinoza L, Hall HI, Surendera-Babu A, Tang T, Chen M. Migration after HIV diagnosis, United States. Presented at the Conference on Retroviruses and Opportunistic Infections, March 3–6, 2014, Boston, Massachusetts.

** <http://www.cdc.gov/hiv/policies/hip.html>.

ethnic groups (8). CDC also supports using surveillance data to 1) identify persons who are not currently in care, 2) improve HIV care engagement, and 3) increase viral suppression (9). Continued collaboration among health care providers, community-based organizations, and state and local health departments can strengthen programs that support both early linkage to care after HIV diagnosis across all racial/ethnic groups and expansion of proven methods for improving retention in care (e.g., HIV case management, patient navigation systems, and co-location of medical services) (7,10).

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