

2020 IHIPC Priority Populations for Targeted Prevention Services and Interventions

Approved by the Illinois HIV Integrated Planning Council_6.28.19

Priority Pop. and Rank	Weighted Priority (%)	Sub-Populations and Rank	Weighted Priority (%)	Female (%)	Male (%)
1: MSM	72.6	1.1 NH Black MSM	30.2		30.2
		1.2 NH White MSM	22.1		22.1
		1.3 Hispanic MSM	16.0		16.0
		1.4 Other MSM	4.2		4.2
2: Het. Cont.	20.2	2.1 NH Black HRH	11.2	7.5	3.7
		2.2 NH White HRH	4.6	2.6	2.0
		2.3 Hispanic HRH	3.5	1.6	1.9
		2.4 Other HRH	0.9	0.4	0.5
3: PWID	3.9	3.1 NH White PWID	1.6	0.9	0.8
		3.2 NH Black PWID	1.5	0.7	0.8
		3.3 Hispanic PWID	0.6	0.2	0.4
		3.4 Other PWID	0.3	0.1	0.2
4: MSM/WID	3.3	4.1 NH White MSM/WID	1.7		1.7
		4.2 NH Black MSM/WID	0.8		0.8
		4.3 Hispanic MSM/WID	0.6		0.6
		4.4 Other MSM/WID	0.1		0.1
Perinatal	Not Included				
Total	100.0		100.0	13.9	86.1

Prioritized Populations Ranking. Statewide HIV prevention services should reach each priority population and sub-population in equal proportion to the percentages specified in the table above.

The priority populations were derived using statewide surveillance data on the epidemic (excluding the city of Chicago). HIV disease incident cases and late diagnosis cases between 2013 and 2017 were used. HIV disease prevalence data at the end of 2017 were also used but included virally unsuppressed cases only. Prevalence data was collected based on current residence. In order to maximize proportional accuracy, this process only considers cases with known exposure category.

Upon recommendation by the Illinois HIV Integrated Planning Council (IHIPC) Epi Profile/Needs Assessment Committee, weights of 90% incidence, 5% prevalence of virally unsuppressed individuals, and 5% late diagnosis have been applied to each set of data. The numbers on the table above are rounded to the nearest tenth percent.

Source: Illinois Department of Public Health, HIV Surveillance Unit. Data as of March 2019.

*The percentages above are weighted averages, which mean that components of the average (incidence, prevalence, and late diagnosis) have been factored by importance. Therefore, any independent incidence, prevalence, or late diagnosis rates referred to in the next section will differ from the above analysis.

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Note: All data cited in the following sections refers to HIV disease diagnoses and trends in Illinois excluding Chicago.

Other Prioritization Recommendations:

- **HIV+ individuals** falling within any of the risks identified above should be prioritized within each subpopulation category.
- **HIV positive persons with “Other Risk”** (i.e. persons not known to meet the MSM, PWID, HRH, or MSM/PWID definitions) are solely prioritized for biomedical interventions intended to link or reengage them into HIV medical treatment and to strengthen their treatment adherence. Upon disclosure of a relevant risk, they may be prioritized for sexual or injection risk reduction interventions.

Points of Consideration:

MSM

- HIV prevention services need to reach men who have sex with men (MSM). MSM accounted for the majority (73%) of new HIV disease diagnoses from 2013-2017.¹ Of these MSM, 42% were non-Hispanic black men, 22% were Hispanic men, and 30% were non-Hispanic white men.¹ Despite a decrease in overall diagnoses from 2008-2017, the number of HIV diagnoses among MSM increased during that period by 24%.¹ Fortunately, during the last 5 years of that period (2013-2017), even MSM HIV diagnoses declined by 4%.¹ The highest proportion of MSM late testers between 2013 and 2017 were Hispanic and aged 30-39.¹

From 2008-2017, the number of new HIV diagnoses among those 20-24 years of age increased. MSM accounted for the majority (88%) of new HIV diagnoses among all youth (aged 13-24) from 2013-2017.¹ Fifty-eight percent of these cases were black and 18% were Hispanic.¹ At the end of 2017, black MSM represented 43% of youth living with HIV.¹ Therefore, young MSM need to be prioritized within MSM targeted work.

Regional differences of MSM incident cases by race/ethnicity need to be considered. To avoid service disparities and to focus services on new diagnoses, each region's HIV Prevention service goals should aim to serve MSM by race and ethnicity in proportion to their share of the total incidence within that region. Note: The largest proportion of new diagnoses for black MSM occurred in census tracts where $\geq 11\%$ of the population was unemployed, $\geq 18\%$ lived below the federal poverty level, and where the median household income was $< \$44,000$.^{1,3}

Heterosexual Exposure

- Precise targeting of the highest risk heterosexuals is needed. Heterosexual exposure accounted for 19% of the new HIV diagnoses from 2013-2017.¹ Of these cases, over 56% were black, 23% were white, and 17% were Hispanic.¹ Heterosexuals experienced a 37% decrease in HIV diagnoses between 2013 and 2017. Additionally, new HIV cases among heterosexual youth decreased from 2008-2017.¹ While the HIV positivity rate among tested heterosexuals is relatively low compared to other transmission categories, the service volume reaching this group has historically been the largest of any exposure category. Nonetheless, 38% of HIV diagnosed heterosexuals received a late diagnosis from 2013-2017, with the highest proportions among Blacks and aged 40-49.¹ This late diagnosis disparity indicates the need for more precisely target service delivery to those heterosexuals mostly likely to transmit or acquire HIV as described by the prioritized high-risk heterosexual definitions.

To avoid service disparities and focus services where new heterosexual diagnoses occur, each region's HIV Prevention service goals should aim to serve prioritized high-risk heterosexuals by race and ethnicity in proportion to their share of the total incidence within that region. Note: The largest proportion of new diagnoses for heterosexuals occurred in census tracts where $\geq 16\%$ of the population lived below the federal poverty level, $\geq 8\%$ were unemployed, and where the median household income was $< \$51,000$.^{1,3}

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PWID

- Effective prevention and care retention services for people who inject drugs (PWID) are needed to sustain the decline in new HIV cases among PWID. PWID accounted for 4% of new HIV diagnoses from 2013-2017.¹ Of these cases, 34% were black, 45% were white, and 13% were Hispanic.¹ PWID experienced a 32% decrease in HIV diagnoses between 2013 and 2017.¹ While new HIV diagnoses among PWID as a whole decreased from 2008-2017, new diagnoses remained stable among youth who injected drugs; therefore, youth should be prioritized within PWID-targeted services.¹

To end service disparities and focus services where new injection-transmitted diagnoses continue to occur, each region's HIV Prevention service goals should aim to serve PWID by race and ethnicity in proportion to their share of the total incidence within that region. Note: The largest proportion of new diagnoses for PWID occurred in census tracts where $\geq 15\%$ of the population lived below the federal poverty level, $\geq 7\%$ were unemployed, and where the median household income was $< \$48,000$.^{1,3}

MSM/WID

- Special attention should be paid to the MSM/WID (MSM who also identify as PWID) population. MSM/WID represented approximately 3% of new HIV diagnoses from 2013-2017.¹ These cases were comprised of 53% whites, 24% blacks, and 19% Hispanics.¹ MSM/WID experienced a 43% decrease in HIV diagnoses between 2013 and 2017.¹ While new HIV diagnoses among MSM/WID as a whole decreased from 2008-2017, youth MSM/WID cases increased and should be prioritized within MSM/WID-targeted services.¹

To avoid service disparities and focus services where new MSM/WID diagnoses continue to occur, each region's HIV Prevention service goals should aim to serve MSM/WID by race and ethnicity in proportion to their share of the total incidence within that region.

Other:

- Prevention efforts should target people of color as they are disproportionately infected with HIV. In 2017, estimated rates of new HIV cases among Black men were more than 10 times higher than that of White men and three times higher than that of Hispanic men according to population size.² Black men first HIV diagnosed in 2017 had the following risks: 70% MSM, 7% Heterosexual, 2% PWID, 1% MSM/WID, and 20% other or unreported.¹

Although new HIV cases among women overall declined an average of 7.4% a year from 2008-2017, cases among Black women declined more slowly during that time (5.7% per year).¹ Because of this, the estimated rate of new HIV cases in Black women in 2017 was 31 times higher than that of White women and six times higher than Hispanic women according to population size.² Black women first HIV diagnosed in 2017 had the following risks: 41% Heterosexual, 2% Injection Drug Use, and 57% other or unreported.¹

Additionally, the number of new HIV disease diagnoses among Hispanic people increased 2% from 2008-2017 while numbers of new HIV disease diagnoses decreased overall among both their non-Hispanic black and white counterparts.¹

- Regional service allocations should reflect recent epidemiologic changes, by race/ ethnicity, risk, and age, between and within regions.

References:

1. Illinois Department of Public Health, HIV Surveillance Unit. Data as of December 2018.
2. Illinois Department of Public Health, Epidemiologic Trends in HIV in Illinois [PowerPoint]. February 21, 2019. Presented at the Illinois HIV Integrated Planning Council Meeting.
3. U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates.