2021-2023 IHIPC Priority Populations for Targeted Prevention Services and Interventions

Approved by the Illinois HIV Integrated Planning Council on 4-30-2020

Priority Pop. and Rank	Weighted Priority (%)	Sub-Populations and Rank	Weighted Priority (%)	Female (%)	Male (%)
1: MSM	73.5	1.1 NH Black MSM	30.3		30.3
		1.2 NH White MSM	21.9		21.9
		1.3 Hispanic MSM	17.3		17.3
		1.4 Other MSM	4.1		4.1
2: Het. Cont.	19.6	2.1 NH Black HRH	11.5	7.6	4.0
		2.2 NH White HRH	4.1	2.4	1.7
		2.3 Hispanic HRH	3.2	1.5	1.7
		2.4 Other HRH	0.8	0.4	0.4
3: PWID	3.7	3.1 NH White PWID	1.6	0.7	0.9
		3.2 NH Black PWID	1.4	0.6	0.8
		3.3 Hispanic PWID	0.4	0.1	0.3
		3.4 Other PWID	0.3	0.0	0.2
4: MSM/WID	3.2	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	0.2		0.2
Perinatal	Not Included				
Total	100.0		100.0	13.3	86.7

<u>Prioritized Populations Ranking</u>. 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 2014 and 2018 were used. HIV disease prevalence data at the end of 2018 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 February 2020.

**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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Other Prioritization Recommendations:

- Because of the disproportionate impact and inequities in HIV transmission specifically seen among **the transgender and Black and Latino men who have sex with men (MSM) communities in Illinois**, providers are strongly encouraged to give special consideration to those communities within any of the priority population categories to reflect **the urgency of their need for services**.
- **Transgender individuals** may be included within any priority population based on personal risk history and current gender identification. Transgender identity does not mean an individual engages in risk behaviors. Medical transition should not be assumed, and unless a transgender client opts to disclose this, risk assessment should assess sexual risks inclusive of the possibilities for male and female anatomy. Transgender females are a high priority for HIV prevention services.
- **HIV positive individuals** should be a top priority within each priority population category based on their identified risks.
- **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.
- **Young adults** should be prioritized within each priority population category when their individual risk histories include prioritized risks defined for that population.
- Persons made vulnerable by circumstances such as incarceration or domestic violence may be prioritized in any risk group when their individual risk and biomedical histories include prioritized risks defined for that population.

Points of Consideration: (*Note: All data cited in the following section refers to HIV disease diagnoses and trends in Illinois excluding Chicago.)*

MSM

- HIV prevention services need to reach men who have sex with men (MSM). MSM accounted for the majority (74%) of new HIV disease diagnoses from 2014-2018.[1] Of these MSM, 41% were non-Hispanic black men, 24% were Hispanic men, and 29% were non-Hispanic white men.[1] Despite a decrease in overall diagnoses from 2009-2018, the number of HIV diagnoses among MSM increased during that period by 3%.[1] However, during the last 5 years of that period (2014-2018), even MSM HIV diagnoses declined by 1%.[1] The highest proportion of MSM late testers between 2014 and 2018 were black and aged 25-29.[1]

  Young MSM need to be prioritized within MSM targeted work. From 2009-2018, 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 2014-2018.[1] Of these cases, 59% were black and 19% were Hispanic.[1] At the end of 2018, black MSM represented 43% of all youth living with HIV.[1]

  Note: The largest proportion of new diagnoses for black MSM occurred in census tracts where ≥ 9% of the population was unemployed, ≥ 11% lived below the federal poverty level, and where the median household income was ≤ $43,000.[1,3]

Heterosexual Exposure

- Precise targeting of the highest risk heterosexuals is needed. Heterosexual exposure accounted for 19% of the new HIV diagnoses from 2014-2018.[1] Of these cases, over 59% were black, 21% were white, and 16% were Hispanic.[1] Heterosexuals experienced a 32% decrease in HIV diagnoses between 2009 and 2018. Additionally, new HIV cases among heterosexual youth remained relatively stable from 2009-2018.[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, 33% of HIV diagnosed heterosexuals received a late diagnosis from 2014-2018, with the highest proportions among Blacks and those aged 40-49.[1] This late diagnosis

disparity indicates the need for more precisely targeted service delivery to those heterosexuals mostly likely to transmit or acquire HIV as described by the prioritized high-risk heterosexual definitions.

Note: The largest proportion of new diagnoses for heterosexuals occurred in census tracts where ≥ 11% of the population lived below the federal poverty level, ≥ 7% were unemployed, and where the median household income was ≤ $47,000.[1,3]

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 3% of new HIV diagnoses from 2014-2018.[1] Of these cases, 34% were black, 49% were white, and 10% were Hispanic.[1] PWID experienced a 25% decrease in HIV diagnoses between 2014 and 2018.[1] Additionally, there were no new cases in 2018 amongst youth who injected drugs.

  Note: The largest proportion of new diagnoses for PWID occurred in census tracts where ≥ 8% of the population lived below the federal poverty level, ≥ 6% were unemployed, and where the median household income was ≤ $47,000.[1,3]

MSM/WID

- Considerations should also be made for the MSM/WID (MSM who also identify as PWID) population. MSM/WID represented approximately 3% of new HIV diagnoses from 2014-2018.[1] Of these cases, 54% were white, 22% were black, and 19% were Hispanic.[1] MSM/WID experienced a 35% decrease in HIV diagnoses between 2014 and 2018.[1]

Other:

- Prevention efforts should target people of color as they are disproportionately infected with HIV. In 2018, estimated rates of new HIV cases among Black men were nearly 8 (7.98) times higher than that of White men and more than two (2.36) times higher than that of Hispanic men according to population size.[2] Black men first HIV diagnosed in 2018 had the following risks: 63% MSM, 12% Heterosexual, 1% PWID, 1% MSM/WID, and 22% other or unreported.[1]

  Although new HIV cases among women overall declined an average of 5.13% a year from 2009-2018, cases among Black women declined more slowly during that time (4.17% per year).[2] Because of this, the estimated rate of new HIV cases in Black women in 2018 was 33 times higher than that of White women and nine times higher than Hispanic women according to population size.[2] Black women first HIV diagnosed in 2018 had the following risks: 55% Heterosexual, 4% Injection Drug Use, and 41% other or unreported.[1]

  Additionally, the number of new HIV disease diagnoses among Hispanic people increased 2% (2.83; not significant) from 2009-2018 while numbers of new HIV disease diagnoses decreased overall among both their non-Hispanic black and white counterparts (Note: -2.27% among blacks and -3.15% among whites, both statistically significant).[2]

- Regional service allocations should aim to serve prioritized populations by race/ethnicity and age in proportion to their share of the weighted HIV epidemic within that region.

References:

1. Illinois Department of Public Health, HIV Surveillance Unit. Data as of December 2019.
2. Illinois Department of Public Health, Epidemiologic Trends in HIV in Illinois [PowerPoint]. March 16, 2020. Presented at the Illinois HIV Integrated Planning Council Meeting.
3. U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates.