2017 ILHPG Priority Populations-Final

As approved by the ILHPG April 15, 2016

Priority Pop. and Rank	Weighted Priority (%)	Sub-Populations and Rank	Weighted Priority (%)	Female (%)	Male (%)
1: MSM	66.3	1.1 NH Black MSM	27.3		27.3
		1.2 NH White MSM	22.4		22.4
		1.3 Hispanic MSM	12.8		12.8
		1.4 Other MSM	3.9		3.9
2: Het. Cont.	24.3	2.1 NH Black HRH	13.4	8.7	4.6
		2.2 NH White HRH	5.5	3.4	2.1
		2.3 Hispanic HRH	4.0	1.8	2.1
		2.4 Other HRH	1.5	0.7	0.8
3: PWID	6.0	3.1 NH Black PWID	2.8	1.2	1.6
		3.2 NH White PWID	2.2	1.1	1.1
		3.3 Hispanic PWID	0.8	0.2	0.6
		3.4 Other PWID	0.2	0.0	0.2
4: MSM/PWID	3.3	4.1 NH White MSM/PWID	1.6		1.6
		4.2 NH Black MSM/PWID	0.9		0.9
		4.3 Hispanic MSM/PWID	0.6		0.6
		4.4 Other MSM/PWID	0.3		0.3
Perinatal	Not Included				
Total	100.0		100.0	17.1	82.9

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 2010 and 2014, and HIV disease prevalence data as of 12/31/15 were used. Prevalence data was collected based on residence at diagnosis. In order to maximize proportional accuracy, this process only considers cases with known exposure category.

Upon recommendation by the ILHPG Epi Profile/Needs Assessment Committee, weights of 90%, 5%, and 5%, respectively, were 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 December 2015.

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Prioritization Points of Consideration

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.

Recommendations:

MSM

1. HIV prevention services need to reach MSM. MSM accounted for the majority (67%) of new HIV cases from 2010-2014.[1] While Black MSM comprise an estimated 0.3% of the Illinois population, they account for 28% of the total HIV incidence in Illinois.[1] Regional differences of MSM incident cases by race/ethnicity need to be taken into account. To avoid service disparities and to focus services on new infections, 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.

2. New cases among youth, especially young MSM, are growing faster than any other group and need to be prioritized. From 2000-2013, the rate of HIV disease diagnoses among youth (aged 13-24) increased by 82% from 11.8 to 21.5 diagnoses per 100,000.[3] 68% of all youth with new HIV diagnoses were Black, and 14% were Hispanic.[3] From 2009-2013, Youth accounted for 23.5% of new HIV diagnoses in Illinois.[3] Of these youth, 85% identified as MSM. [3] Young adults (aged 20-29) accounted for 42% of new HIV diagnoses among MSM.[2] At the end of 2013, Black MSM represented 42% of youth living with HIV.[3]

Heterosexual Exposure

3. Precise targeting of the highest risk heterosexuals is needed. Heterosexual exposure accounted for 24% of the new HIV cases between 2010 and 2014, and the proportion of cases attributed to this risk has decreased since 2009. [1] While the HIV positivity rate among heterosexuals tested is low, the service volume reaching this group is the largest of any exposure category. Nonetheless, heterosexuals were approximately 25% more likely to be diagnosed ***late*** when compared to MSM.[1] This late diagnosis disparity indicates the need to more precisely targeted 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 on new infections, 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.

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. New HIV cases among PWID averaged 6% of the epidemic between 2010 and 2014, a percentage that has steadily declined since 2003.[1] This decline may be attributable to many factors. A 2003 Illinois law legalized sterile syringe access via pharmacy purchase throughout Illinois. Injection harm reduction counseling taught safer injection practices to networks of persons injecting. Risk targeted HIV testing helped to diagnose and link to treatment HIV-infected people who inject drugs (PWID). Improved HIV treatments reduced the infectiousness of actively injecting HIV-diagnosed persons in care. As PWID were approximately 10% more likely than MSM to have a ***late*** diagnosis,[1] testing must implement strategies to reach beyond regularly served harm reduction clients to engage as of yet unserved injecting individuals and networks. Black and Hispanic injectors, compared to White injectors, remain underserved relative to their proportion of new infections. As PWID are least likely to be engaged and retained in care and virally suppressed [4], care

engagement and retention efforts must prioritize these disparities. To end service disparities and focus services where new injection-transmitted infections 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.

MSM/PWID

Special attention should be paid to the MSM/PWID population. MSM/PWID represented about 3% of diagnoses between 2010 and 2014 a percentage that has gradually declined since 2003.[1] 40% of MSM/PWID diagnosed with during 2005-2014 received a late diagnosis[6]. Given that MSM/PWID received 4.8% of 2015 Regional grant funded tests, more than an incidence-proportioned share, the late diagnosis disparity suggests that MSM/PWID testing must implement social networking strategies to reach beyond regularly served harm reduction clients to engage as of yet unserved injecting MSM. To avoid service disparities and focus services where new MSM/PWID infections continue to occur, each region's HIV Prevention service goals should aim to serve MSM/PWID by race and ethnicity in proportion to their share of the total incidence within that region.

Other recommendations:

1. Within each prioritized population, special attention should be paid to test populations with high rates of late diagnoses who fall within any of the risks identified above. From 2010- 2014, the proportion of new HIV diagnoses that were late among Blacks was 30%. Whites and Hispanics were 19% and 23%, respectively, more likely than Blacks to receive a late diagnosis.[1] Rates of late HIV diagnosis from 2010-2014 were similar in males (34%) and females (36%).[1] 2008-2012 trends showed that the likelihood of a late HIV diagnosis increased with age and that rates across rural (33%) and urban (32%) counties were also similar.[5]

2. Prevention efforts should target African Americans, especially MSM, as they are disproportionately infected with HIV. In 2014, estimated rates of new HIV infection in African American men in Illinois (excluding Chicago) were nine times higher than that of white men and three times higher than that of Hispanic men according to population size.[6] The estimated rate of new HIV infection in African American women was 15 times higher than that of white women according to population size.[6]

3. 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 2015.
2. Illinois Department of Public Health. *Men Who Have Sex with Men,* 2015. http://dph.illinois.gov/sites/default/files/publications/1-27-16-OHP-HIV-factsheet-MSM.pdf
3. Illinois Department of Public Health. *Youth,* 2015. http://dph.illinois.gov/sites/default/files/publications/1-29-16-OHP-HIV-factsheet-Youth.pdf
4. Illinois Department of Public Health, *Illinois HIV Linkage to Care and HIV Care Continuum, 2014,* December 3, 2015 ILHPG meeting presentation.
5. Illinois Department of Public Health. *Late HIV Diagnosis,* 2015. http://dph.illinois.gov/sites/default/files/publications/1-25-16-OHP-HIV-factsheet-Late-HIV-Diagnosis.pdf
6. Illinois Department of Public Health. *Epidemiologic Trends in HIV in Illinois.* March 17, 2016 Integrated ILHPG/ RW Advisory Group Meeting.