Basic Information about HIV and AIDS

While there have been great strides in the prevention of HIV transmission and care of HIV infection and AIDS since AIDS was first recognized in 1981, many people still have questions about HIV and AIDS. The information below is designed to answer some of these questions based on the best available science.

What are HIV and AIDS?

Electron microscope image of HIV, seen as small spheres on the surface of white blood cells.

HIV is the human immunodeficiency virus. It is the virus that can lead to acquired immune deficiency syndrome, or AIDS. CDC estimates that about 56,000 people in the United States contracted HIV in 2006.

There are two types of HIV, HIV-1 and HIV-2. In the United States, unless otherwise noted, the term “HIV” primarily refers to HIV-1. Both types of HIV damage a person’s body by destroying specific blood cells, called CD4+ T cells, which are crucial to helping the body fight diseases.

Within a few weeks of being infected with HIV, some people develop flu-like symptoms that last for a week or two, but others have no symptoms at all. People living with HIV may appear and feel healthy for several years. However, even if they feel healthy, HIV is still affecting their bodies. All people with HIV should be seen on a regular basis by a health care provider experienced with treating HIV infection. Many people with HIV, including those who feel healthy, can benefit greatly from current medications used to treat HIV infection. These medications can limit or slow down the destruction of the immune system, improve the health of people living with HIV, and may reduce their ability to transmit HIV. Untreated early HIV infection is also associated with many diseases including cardiovascular disease, kidney disease, liver disease, and cancer. Support services are also available to many people with HIV. These services can help people cope with their diagnosis, reduce risk behavior, and find needed services.

AIDS is the late stage of HIV infection, when a person’s immune system is severely damaged and has difficulty fighting diseases and certain cancers. Before the development of certain medications, people with HIV could progress to AIDS in just a few years. Currently, people can live much longer - even decades - with HIV before they develop AIDS. This is because of “highly active” combinations of medications that were introduced in the mid 1990s.
No one should become complacent about HIV and AIDS. While current medications can dramatically improve the health of people living with HIV and slow progression from HIV infection to AIDS, existing treatments need to be taken daily for the rest of a person’s life, need to be carefully monitored, and come with costs and potential side effects. At this time, there is no cure for HIV infection. Despite major advances in diagnosing and treating HIV infection, in 2007, 35,962 cases of AIDS were diagnosed and 14,110 deaths among people living with HIV were reported in the United States.

Where did HIV come from?

Scientists identified a type of chimpanzee in West Africa as the source of HIV infection in humans. They believe that the chimpanzee version of the immunodeficiency virus (called simian immunodeficiency virus or SIV) most likely was transmitted to humans and mutated into HIV when humans hunted these chimpanzees for meat and came into contact with their infected blood. Over decades, the virus slowly spread across Africa and later into other parts of the world.

HIV-2

In 1986, a second type of HIV, called HIV-2, was isolated from AIDS patients in West Africa. HIV-2 has the same modes of transmission as HIV-1 and is associated with similar opportunistic infections and AIDS. In persons infected with HIV-2, immunodeficiency seems to develop more slowly and to be milder, and those with HIV-2 are comparatively less infectious early in the course of infection. As the disease advances, HIV-2 infectiousness seems to increase; however, compared with HIV-1, the duration of this increased infectiousness is shorter.

HIV-2 infections are predominantly found in Africa. West African nations with a prevalence of HIV-2 of more than 1% in the general population are Cape Verde, Côte d'Ivoire (Ivory Coast), Gambia, Guinea-Bissau, Mali, Mauritania, Nigeria, and Sierra Leone. Other West African countries reporting HIV-2 are Benin, Burkina Faso, Ghana, Guinea, Liberia, Niger, São Tomé, Senegal, and Togo. Angola and Mozambique are other African nations where the prevalence of HIV-2 is more than 1%.

The first case of HIV-2 infection in the United States was diagnosed in 1987. Since then, the Centers for Disease Control and Prevention (CDC) has worked with state and local health departments to collect demographic, clinical, and laboratory data on persons with HIV-2 infection.

How is HIV spread?

HIV is spread primarily by:

- Not using a condom when having sex with a person who has HIV. All unprotected sex with someone who has HIV contains some risk. However:
  - Unprotected anal sex is riskier than unprotected vaginal sex.
  - Among men who have sex with other men, unprotected receptive anal sex is riskier than unprotected insertive anal sex.
- Having multiple sex partners or the presence of other sexually transmitted diseases (STDs) can increase the risk of infection during sex. Unprotected oral sex can also be a risk for HIV
transmission, but it is a much lower risk than anal or vaginal sex.

- Sharing needles, syringes, rinse water, or other equipment used to prepare illicit drugs for injection.
- Being born to an infected mother—HIV can be passed from mother to child during pregnancy, birth, or breast-feeding.

Less common modes of transmission include:

- Being “stuck” with an HIV-contaminated needle or other sharp object. This risk pertains mainly to healthcare workers.
- Receiving blood transfusions, blood products, or organ/tissue transplants that are contaminated with HIV. This risk is extremely remote due to the rigorous testing of the U.S. blood supply and donated organs/tissue.
- HIV may also be transmitted through unsafe or unsanitary injections or other medical or dental practices. However, the risk is also remote with current safety standards in the U.S.
- Eating food that has been pre-chewed by an HIV-infected person. The contamination occurs when infected blood from a caregiver’s mouth mixes with food while chewing. This appears to be a rare occurrence and has only been documented among infants whose caregiver gave them pre-chewed food.
- Being bitten by a person with HIV. Each of the very small number of cases has included severe trauma with extensive tissue damage and the presence of blood. There is no risk of transmission if the skin is not broken.
- Contact between broken skin, wounds, or mucous membranes and HIV-infected blood or blood-contaminated body fluids. These reports have also been extremely rare.
- There is an extremely remote chance that HIV could be transmitted during “French” or deep, open-mouth kissing with an HIV-infected person if the HIV-infected person’s mouth or gums are bleeding.
- Tattooing or body piercing present a potential risk of HIV transmission, but no cases of HIV transmission from these activities have been documented. Only sterile equipment should be used for tattooing or body piercing.
- There have been a few documented cases in Europe and North Africa where infants have been infected by unsafe injections and then transmitted HIV to their mothers through breastfeeding. There have been no documented cases of this mode of transmission in the U.S.

HIV cannot reproduce outside the human body. It is not spread by:

- Air or water.
- Insects, including mosquitoes. Studies conducted by CDC researchers and others have shown no evidence of HIV transmission from insects.
- Saliva, tears, or sweat. There is no documented case of HIV being transmitted by spitting.
- Casual contact like shaking hands or sharing dishes.
- Closed-mouth or “social” kissing.
All reported cases suggesting new or potentially unknown routes of transmission are thoroughly investigated by state and local health departments with assistance, guidance, and laboratory support from CDC.

**How do HIV tests work?**

The most commonly used HIV tests detect HIV antibodies – the substances the body creates in response to becoming infected with HIV. There are tests that look for HIV's genetic material or proteins directly; these may also be used to find out if someone has been infected with HIV.

It can take some time for the immune system to produce enough antibodies for the antibody test to detect, and this “window period” between infection with HIV and the ability to detect it with antibody tests can vary from person to person. During this time, HIV viral load and the likelihood of transmitting the virus to sex or needle-sharing partners may be very high. Most people will develop detectable antibodies that can be detected by the most commonly used tests in the United States within 2 to 8 weeks (the average is 25 days) of their infection. Ninety-seven percent (97%) of persons will develop detectable antibodies in the first 3 months. Even so, there is a small chance that some individuals will take longer to develop detectable antibodies. Therefore, a person should consider a follow-up test more than three months after their last potential exposure to HIV. In extremely rare cases, it can take up to 6 months to develop antibodies to HIV.

Conventional HIV tests are sent to a laboratory for testing, and it can take a week or two before the test results are available. There are also rapid HIV tests available that can give results in as little as 20 minutes. A positive HIV test result means that a person may have been infected with HIV. All positive HIV test results, regardless of whether they are from rapid or conventional tests, must be verified by a second “confirmatory” HIV test.

**How can HIV be prevented?**

Because the most common ways HIV is transmitted is through anal or vaginal sex or sharing drug injection equipment with a person infected with HIV, it is important to take steps to reduce the risks associated with these. They include:

- Know your HIV status. Everyone between the ages of 13 and 64 should be tested for HIV at least once. If you are at increased risk for HIV, you should be tested for HIV at least once a year.
  - If you have HIV, you can get medical care, treatment, and supportive services to help you stay healthy and reduce your ability to transmit the virus to others.
  - If you are pregnant and find that you have HIV, treatments are available to reduce the chance that your baby will have HIV.
- Abstain from sexual activity or be in a long-term mutually monogamous relationship with an uninfected partner.
- Limit your number of sex partners. The fewer partners you have, the less likely you are to encounter someone who is infected with HIV or another STD.
- Correct and consistent condom use. Latex condoms are highly effective at preventing transmission of HIV and some other sexually transmitted diseases. "Natural" or lambskin condoms do not provide sufficient
protection against HIV infection.

- Get tested and treated for STDs and insist that your partners do too.
- Male circumcision has also been shown to reduce the risk of HIV transmission from women to men during vaginal sex.
- Do not inject drugs. If you inject drugs, you should get counseling and treatment to stop or reduce your drug use. If you cannot stop injecting drugs, use clean needles and works when injecting.
- Obtain medical treatment immediately if you think you were exposed to HIV. Sometimes, HIV medications can prevent infection if they are started quickly. This is called post-exposure prophylaxis.
- Participate in risk reduction programs. Programs exist to help people make healthy decisions, such as negotiating condom use or discussing HIV status. Your health department can refer you to programs in your area.

If you would like more information or have personal concerns, call CDC-INFO 24 Hours/Day at 1-800-CDC-INFO (232-4636), 1-888-232-6348 (TTY), in English, en Español

Many of the facts explained above come from studies published in scientific journals. Some of those studies are listed below.

9. Lytle, Routson, Seaborn, Dixon, Bushar, & Cyr. An in vitro evaluation of condoms as barriers to a small virus. Sexually Transmitted Diseases 1997; 24(3)
CDC estimates that more than one million people are living with HIV in the United States (US). One in five (21%) of those people living with HIV is unaware of their infection.

Despite increases in the total number of people living with HIV in the US in recent years, the annual number of new HIV infections has remained relatively stable. However, new infections continue at far too high a level, with an estimated 56,300 Americans becoming infected with HIV each year.

More than 18,000 people with AIDS still die each year in the US. Gay, bisexual, and other men who have sex with men (MSM) are strongly affected and represent the majority of persons who have died. Through 2007, more than 576,000 people with AIDS in the US have died since the epidemic began.

By Risk Group
Gay, Bisexual, and Other Men Who Have Sex with Men (MSM): By risk group, gay, bisexual, and other MSM of all races remain the population most severely affected by HIV.

• MSM account for more than half (53%) of all new HIV infections in the US each year, as well as nearly half (48%) of people living with HIV.

• While CDC estimates that MSM account for just 4% of the US male population aged 13 and older, the rate of new HIV diagnoses among MSM in the US is more than 44 times that of other men and more than 40 times that of women.

• White MSM account for the largest number of annual new HIV infections of any group in the US, followed closely by black MSM.

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*This fact sheet highlights key information about those most affected by HIV in the United States. For information about other risk populations, visit www.cdc.gov/hiv.

¹The term men who have sex with men (MSM) is used in CDC surveillance systems. It indicates the behaviors that transmit HIV infection, rather than how individuals self-identify in terms of their sexuality.
HIV in the United States

Additional Resources:

CDC HIV and AIDS
www.cdc.gov/hiv
Visit CDC’s HIV and AIDS Web site.

CDC-INFO
1-800-CDC-INFO or 1-800 (232-4636) cdcinfo@cdc.gov
Get information about personal risk, prevention, and testing.

CDC National HIV Testing Resources
www.hivtest.org
Text your ZIP code to KNOW IT or 566948 Locate an HIV testing site near you.

CDC National Prevention Information Network (CDC NPIN)
1-800-458-5231 www.cdcnpin.org
Find CDC resources and technical assistance.

AIDSinfo
1-800-448-0440 www.aidsinfo.nih.gov
Locate resources on HIV and AIDS treatment and clinical trials.

• MSM is the only risk group in the US in which new HIV infections have been increasing since the early 1990s.

Heterosexuals and Injection Drug Users:
Heterosexuals and injection drug users also continue to be affected by HIV.
- Individuals infected through heterosexual contact account for 31% of annual new HIV infections and 28% of people living with HIV.
- As a group, women account for 27% of annual new HIV infections and 25% of those living with HIV.
- Injection drug users represent 12% of annual new HIV infections and 19% of those living with HIV.

• At some point in their life, approximately one in 16 black men will be diagnosed with HIV, as will one in 30 black women.

• The rate of new HIV infections for black men is about six times as high as that of white men, nearly three times that of Hispanic/Latino men, and more than twice that of black women.

• The HIV incidence rate for black women is nearly 15 times as high as that of white women, and nearly four times that of Hispanic/Latino women.

By Race/Ethnicity

African Americans: Among racial/ethnic groups, African Americans face the most severe burden of HIV in the US.
- While blacks represent approximately 12% of the US population, they account for almost half (46%) of people living with HIV in the US, as well as nearly half (45%) of new infections each year. HIV infections among blacks overall have been roughly stable since the early 1990s.

Hispanics/Latinos: Hispanics/Latinos are also disproportionately impacted.
- Hispanics/Latinos represent 15% of the population but account for an estimated 17% of people living with HIV and 17% of new infections. HIV infections among Hispanics/Latinos overall have been roughly stable since the early 1990s.

- The rate of new HIV infections among Hispanic/Latino men is more than double that of white men and the rate among Hispanic/Latino women is nearly four times that of white women.
Gay, bisexual, and other men who have sex with men (MSM)1 represent approximately 2% of the US population, yet are the population most severely affected by HIV and are the only risk group in which new HIV infections have been increasing steadily since the early 1990s. In 2006, MSM accounted for more than half (53%) of all new HIV infections in the United States, and MSM with a history of injection drug use (MSM-IDU) accounted for an additional 4% of new infections. At the end of 2006, more than half (53%) of all people living with HIV in the United States were MSM or MSM-IDU. Since the beginning of the US epidemic, MSM have consistently represented the largest percentage of persons diagnosed with AIDS and persons with an AIDS diagnosis who have died.

The Numbers

New HIV Infections2

- In 2006, more than 30,000 MSM and MSM-IDU were newly infected with HIV.
- Among all MSM, whites accounted for nearly half (46%) of new HIV infections in 2006. The largest number of new infections among white MSM occurred in those aged 30–39 years, followed by those aged 40–49 years.
- Among all black MSM, there were more new HIV infections (52%) among young black MSM (aged 13–29 years) than any other racial or ethnic age group of MSM in 2006. The number of new infections among young black MSM was nearly twice that of young white MSM and more than twice that of young Hispanic/Latino MSM.
- Among all Hispanic/Latino MSM in 2006, the largest number of new infections (43%) occurred in the youngest age group (13–29 years), though a substantial number of new HIV infections (35%) were among those aged 30–39 years.

HIV and AIDS Diagnoses3 and Deaths

- A recent CDC study found that in 2008 one in five (19%) MSM in 21 major US cities were infected with HIV, and nearly half (44%) were unaware of their infection. In this study, 28% of black MSM were HIV-infected, compared to 18% of Hispanic/Latino MSM and 16% of white MSM. Other racial/ethnic groups of MSM also have high numbers of HIV infections, including American Indian/Alaska Native MSM (20%) and Native Hawaiian/Pacific Islander MSM (18%).
- In 2007, MSM were 44 to 86 times as likely to be diagnosed with HIV compared with other men, and 40 to 77 times as likely as women.
- From 2005–2008, estimated diagnoses of HIV infection increased approximately 17% among MSM. This increase was likely due to a combination of factors: increases in new infections, increased testing, and diagnosis earlier in the course of infection; it may also have been due to uncertainty in statistical models.

1The term men who have sex with men (MSM) is used in CDC surveillance systems. It indicates the behaviors that transmit HIV infection, rather than how individuals self-identify in terms of their sexuality.
2New HIV Infections refers to HIV incidence, or the number of people that are newly infected with HIV.
3HIV and AIDS Diagnoses indicates when a person is diagnosed with HIV infection or AIDS but does not indicate when the person was infected.
Additional Resources:

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Locate resources on HIV and AIDS treatment and clinical trials.

For more information, visit the CDC HIV and MSM Web site at www.cdc.gov/hiv/topics/msm.

- In 2008, an estimated 17,940 MSM were diagnosed with AIDS in the 50 states, the District of Columbia, and the US dependent areas—an increase of 6% since 2005.
- By the end of 2007, an estimated 282,542 MSM with an AIDS diagnosis had died in the United States and 5 dependent areas.

Prevention Challenges

The high prevalence of HIV infection among MSM means they face a greater risk of being exposed to infection with each sexual encounter—especially as they get older.

Sexual risk accounts for most HIV infections in MSM. These risks include unprotected sex and sexually transmitted diseases (STDs). The practice of not using a condom during anal sex with someone other than a primary, HIV-negative partner continues to pose a significant threat to the health of MSM.

Alcohol and illicit drug use contributes to increased risk for HIV infection and other STDs among MSM. The use of substances such as alcohol and other drugs can increase the likelihood of risky sexual behavior.

Many MSM with HIV are unaware of their HIV infection, especially MSM of color and young MSM. A recent CDC study found that among urban MSM in 21 cities in 2008 who were unaware of their HIV infection, 55% had not been tested in the previous 12 months. Low awareness of HIV status among young MSM likely reflects several factors: they may have been infected more recently, may underestimate their personal risk, may have had fewer opportunities to get tested, or may believe that HIV treatment minimize the threat of HIV. CDC recommends that all MSM get tested for HIV once a year—and more often if they are at higher risk. MSM at higher risk includes those who have multiple or anonymous sex partners or use drugs during sex.

Stigma and homophobia may have a profound impact on the lives of MSM, especially their mental and sexual health. Internalized homophobia may impact men’s ability to make healthy choices, including decisions around sex and substance use. Stigma and homophobia may limit the willingness of MSM to access HIV prevention and care, isolate them from family and community support, and create cultural barriers that inhibit integration into social networks.

Racism, poverty, and lack of access to health care are barriers to HIV prevention services, particularly for MSM from racial or ethnic minority communities. A recent CDC study found a strong link between socioeconomic status and HIV among MSM: prevalence increased as education and income decreased, and awareness of HIV status was higher among MSM with greater education and income.

Complacency about HIV may play a key role in HIV risk, particularly among young MSM. Since young MSM did not experience the severity of the early HIV epidemic, some may falsely believe that HIV is no longer a serious health threat because of treatment advances and decreased mortality. Additional challenges for many MSM include maintaining safe behaviors over time and underestimating personal risk.

What CDC Is Doing

In fiscal year 2009, 43% of CDC’s Division of HIV/AIDS Prevention’s budget was targeted towards MSM and MSM-IDU. CDC provides funding for state and local health departments and community-based organizations to support HIV prevention services for MSM in a variety of settings, including MSM of color and young transgender persons of color.

CDC supports the training and technical assistance for five HIV prevention interventions that focus on MSM and two additional interventions that were developed for HIV-positive MSM and others living with HIV.

CDC conducts research to better understand the factors that lead to HIV infection and identify effective approaches to prevent infection among MSM—especially MSM who are at greatest risk. Research includes diagnostic tests, microbicides, pre- and post-exposure prophylaxis, vaccines, and behavioral research on health disparities.

CDC carefully monitors HIV and risk behaviors by race, age, risk group (including MSM), and gender, enabling communities to base HIV prevention strategies on the best possible understanding of the epidemic.

Through various communications and collaboration activities, CDC aims to provide MSM with effective and culturally appropriate messages about HIV prevention. CDC uses strategies such as social marketing, fact sheets, web-based information, and other resources to maintain the timeliness of HIV/AIDS information and encourage behavior change.
HIV among African Americans

By race/ethnicity, African Americans face the most severe burden of HIV in the United States (US). At the end of 2007, blacks accounted for almost half (46%) of people living with a diagnosis of HIV infection in the 37 states and 5 US dependent areas with long-term, confidential, name-based HIV reporting. In 2006, blacks accounted for nearly half (45%) of new infections in the 50 states and the District of Columbia. Even though new HIV infections among blacks overall have been roughly stable since the early 1990s, compared with members of other races and ethnicities they continue to account for a higher proportion of cases at all stages of HIV—from new infections to deaths.

The Numbers

New HIV Infections1

- In 2006, black men accounted for two-thirds of new infections (65%) among all blacks. The rate of new HIV infection for black men was 6 times as high as that of white men, nearly 3 times that of Hispanic/Latino men, and twice that of black women.
- In 2006, black men who have sex with men (MSM) represented 63% of new infections among all black men, and 35% among all MSM. HIV infection rates are higher among black MSM compared to other MSM. More new HIV infections occurred among young black MSM (aged 13–29) than among any other age and racial group of MSM.
- In 2006, the rate of new HIV infection for black women was nearly 15 times as high as that of white women and nearly 4 times that of Hispanic/Latina women.

HIV and AIDS Diagnoses3 and Deaths

- Although new HIV infections have remained fairly stable among blacks, from 2005–2008 estimated HIV diagnoses increased approximately 12%. This may be due to increased testing or diagnosis earlier in the course of HIV infection; it may also be due to uncertainty in statistical models.
- At some point in their lifetimes, 1 in 16 black men will be diagnosed with HIV infection, as will 1 in 30 black women.
- From 2005–2008, the rate of HIV diagnoses among blacks increased from 68/100,000 persons to 74/100,000. This increase reflects the largest increase in rates of HIV diagnoses by race or ethnicity.

1 New HIV Infections refers to HIV incidence, or the number of people that are newly infected with HIV.
2 The term men who have sex with men (MSM) is used in CDC surveillance systems. It indicates the behaviors that transmit HIV infection, rather than how individuals self-identify in terms of their sexuality.
3 HIV and AIDS Diagnoses indicates when a person is diagnosed with HIV infection or AIDS but does not indicate when the person was infected.
• In 2008, an estimated 18,328 blacks received an AIDS diagnosis, a number that has remained relatively stable since 2005.

• By the end of 2007, an estimated 233,624 blacks with a diagnosis of AIDS had died in the US and 5 dependent areas. In 2006, HIV was the ninth leading cause of death for all blacks and the third leading cause of death for both black men and black women aged 35–44.

Prevention Challenges

Like other communities, African Americans face a number of challenges that contribute to the higher rates of HIV infection.

Sexual risk behaviors, such as unprotected sex with multiple partners, with a partner who also has other sex partners, or with persons at high risk for HIV infection can be common in some communities.

Injection drug use can facilitate HIV transmission through the sharing of unclean needles. Casual and chronic substance users may be more likely to engage in unprotected sex under the influence of drugs and/or alcohol.

African Americans continue to experience higher rates of sexually transmitted diseases (STDs) than any other race/ethnicity in the US. The presence of certain STDs can significantly increase the chance of contracting HIV infection. A person who has both HIV infection and certain STDs has a greater chance of infecting others with HIV.

The socioeconomic issues associated with poverty, including limited access to quality health care, housing, and HIV prevention education, directly and indirectly increase the risk for HIV infection and affect the health of people living with HIV.

Lack of awareness of HIV status. In a recent study of men who have sex with men (MSM) in five cities, 67% of the HIV infected black MSM were unaware of their infection.

Stigma also puts too many African Americans at higher risk. Many at risk for HIV infection fear stigma more than knowing their status, choosing instead to hide their high-risk behavior rather than seek counseling and testing.

What CDC Is Doing

CDC has initiated a wide range of activities to (1) better understand those factors that drive the HIV and AIDS epidemic among African Americans in the US, (2) expand HIV testing and access to medical care, (3) develop new interventions and scale up the availability of effective interventions, and (4) mobilize African American communities to combat the HIV crisis. Some examples of CDC activities:

• CDC works closely with state and local health departments and community-based organizations (CBOs) to effectively utilize current HIV prevention interventions proven to be most effective for African Americans.

• CDC research has led to new interventions that reduce HIV risk in African Americans. CDC continues to identify, develop, and evaluate new behavioral and biomedical interventions for individuals at greatest risk and those living with HIV.

• CDC is conducting research to better understand and plan interventions to address the social, community, financial, and structural factors that place many African Americans at risk and hinder access to prevention and care.

• CDC is working with African American leaders from every sector to mobilize communities of color against HIV and deliver culturally appropriate campaigns and messages, including the Act Against AIDS campaign. For more information, visit www.cdc.gov/hiv/aaa.

• In 2010, CDC announced a second 3-year expanded HIV testing program that supplements an initiative started in 2007 to increase HIV testing among African Americans. CDC is expanding the program to an additional five state, territorial, and metropolitan health departments. It also broadens the target population to include African Americans and Hispanics/Latinos, as well as MSM and injection drug users of any race/ethnicity. Funding for the program was increased from $36 million to approximately $62 million.
HIV among Hispanics/Latinos

The HIV epidemic is a serious threat to the Hispanic/Latino community. While Hispanics/Latinos represents approximately 15% of the United States (US) population in 2006, they accounted for 17% of new HIV infections in the 50 states and the District of Columbia during that same year. The rate of new HIV infections among Hispanics/Latinos in 2006 was 2.5 times that of whites.

Estimated Rates of New HIV Infections, by Race/Ethnicity and Gender, 2006


Prevention Challenges
A number of factors contribute to the HIV epidemic in Hispanic/Latino communities.

In 2006, Hispanic/Latino men who have sex with men (MSM) represented 72% of new infections among all Hispanic/Latino men, and nearly 19% among all MSM. Among Hispanic/Latino MSM, 43% occurred in Hispanic/Latino MSM under age 30, and the remaining 57% occurred in Hispanic/Latino MSM aged 30 or older.

While Hispanic/Latino women represented a quarter (24%) of new infections among Hispanics/Latinos in 2006, their rate of HIV infection was nearly four times that of white women (14.4/100,000 vs. 3.8/100,000).

HIV and AIDS Diagnoses and Deaths

- At some point in life, 1 in 36 Hispanic/Latino men will be diagnosed with HIV, as will 1 in 106 Hispanic/Latina women.
- In 2008, Hispanics/Latinos accounted for more than 19% of the 42,439 new diagnoses of HIV infection in the 37 states and 5 US dependent areas with confidential name-based HIV infection reporting.
- In 2008, an estimated 7,864 Hispanics/Latinos were diagnosed with AIDS in the US and dependent areas, which has remained relatively stable since 2005.
- By the end of 2007, an estimated 106,074 Hispanics/Latinos with an AIDS diagnosis had died in the US and dependent areas. In 2007, HIV was the fifth leading cause of death among Hispanics/Latinos aged 35–44 and the sixth leading cause of death among Hispanics/Latinos aged 25–34 in the US.

Fast Facts

1 Hispanics/Latinos can be of any race.
2 New HIV Infections refers to HIV incidence, or the number of people that are newly infected with HIV.
3 The term men who have sex with men (MSM) is used in CDC surveillance systems. It indicates the behaviors that transmit HIV infection, rather than how individuals self-identify in terms of their sexuality.
4 HIV and AIDS Diagnoses indicates when a person is diagnosed with HIV infection or AIDS but does not indicate when the person was infected.
HIV among Hispanics/Latinos

Additional Resources:

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Find CDC resources and technical assistance.

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Locate resources on HIV and AIDS treatment and clinical trials.

- Behavioral risk factors for HIV infection differ by country of birth. Data suggest that Hispanic/Latino men born in Puerto Rico are more likely than other Hispanic/Latino men to contract HIV as a result of injection drug use. By contrast, sexual contact with other men is the primary cause of HIV infections among Hispanic/Latino men born in Central or South America, Cuba, Mexico, and the US.

- Hispanics/Latinos are most likely to be infected with HIV as a result of sexual contact with men. Hispanic/Latina women may be unaware of their male partner’s risk factors or incorrectly assess them. In five different studies of US gay and bisexual men, Hispanics/Latinos were reported to have the highest rates of unprotected male-to-male sexual contact.

- Injection drug use continues to be a risk factor for Hispanics/Latinos, particularly those living in Puerto Rico. Both casual and chronic substance users may be more likely to engage in risky sexual behaviors, such as unprotected sex, when they are under the influence of drugs or alcohol.

- The presence of certain sexually transmitted diseases (STDs) can significantly increase one’s chances of contracting HIV infection. A person who has both HIV infection and certain STDs has a greater chance of infecting others with HIV. The rates of STDs remain high among Hispanics/Latinos.

- Cultural factors may affect the risk of HIV infection. Some Hispanics/Latinos may avoid seeking testing, counseling, or treatment if infected out of fear of discrimination. The stigma around homosexuality adds to prevention challenges (e.g., traditional gender roles and cultural norms such as “machismo” contribute to the perception of Hispanic/Latino gay men as “failed men”).

- Greater acculturation into the US culture has both negative (engaging in behaviors that increase the risk for HIV infection) and positive (communicating with partners about practicing safer sex) effects on the health behaviors of Hispanics/Latinos.

- Socioeconomic factors such as poverty, migration patterns, social structures, or language barriers add to Hispanic/Latino HIV infection rates. Problems associated with socioeconomics include unemployment, transience, a lack of formal education, immigration status, inadequate health insurance, and limited access to quality health care.

What CDC Is Doing

In recent years, CDC has supported research studies to develop new effective behavioral interventions and to adapt existing interventions for Hispanic/Latino populations. CDC also supports the national dissemination of effective HIV behavioral interventions for Hispanics/Latinos. These interventions, in various stages of development and dissemination, include Connect (Connectémonos); ¡Cuide!; Modelo de Intervención Psicomédica (MIP); Project AIM; Project FIO; and Salud, Educación, Prevención y Autocuidado (SEPA).

CDC has also initiated new projects and included language in funding opportunity announcements to expand the HIV prevention services currently available to Hispanics/Latinos. CDC funds states, territories, and community-based organizations (CBOs) within the US, Puerto Rico, and the US Virgin Islands to provide HIV prevention services to high-risk populations including Hispanics/Latinos.

In 2009, as part of CDC’s Act Against AIDS campaign, CDC launched the Act Against AIDS Leadership Initiative (AAALI), a $9 million, five-year partnership to increase HIV-related awareness, knowledge, and action in minority communities across the US. In 2010, CDC expanded AAALI to include three organizations that focus on Hispanic/Latino populations. Also in 2010, CDC placed Spanish Act Against AIDS campaign messages on billboards and bus shelters in predominant Hispanic/Latino neighborhoods in six cities, as well as Spanish dioramas in five airports. CDC also distributed Spanish Act Against AIDS television public service announcements to Univision, Telemundo, TeleFutura, and NBC en Español television networks and their affiliate stations in 34 markets.
Through December 2001, there were 57 documented cases of occupational HIV transmission to health care workers in the United States, and only one reported case has been confirmed since 2001. Occupational transmission of HIV is reported in the Centers for Disease Control and Prevention (CDC) HIV Surveillance Report\(^1\) in the transmission category that includes hemophilia, blood transfusion, perinatal exposure, and risk factor not reported or not identified.

To prevent transmission of HIV to health care workers in the workplace, CDC offers the following recommendations.

**Prevention Strategies**

Health care workers should assume that the blood and other body fluids from all patients are potentially infectious. They should therefore follow infection control precautions at all times. These precautions include:

- routinely using barriers (such as gloves and/or goggles) when anticipating contact with blood or body fluids,
- immediately washing hands and other skin surfaces after contact with blood or body fluids, and
- carefully handling and disposing of sharp instruments during and after use.

Safety devices have been developed to help prevent needle-stick injuries. If used properly, these types of devices may reduce the risk of exposure to HIV. Many percutaneous injuries, such as needle-sticks and cuts, are related to sharps disposal. Strategies for safer disposal, including safer design of disposal containers and placement of containers, are being developed.

Although the most important strategy for reducing the risk of occupational HIV transmission is to prevent occupational exposures, plans for postexposure management of health care personnel should be in place. CDC has issued guidelines for the management of health care worker exposures to HIV and recommendations for postexposure prophylaxis (PEP): Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis\(^2\) (September 30, 2005).

These guidelines outline a number of considerations in determining whether health care workers should receive PEP and in choosing the type of PEP regimen. For most HIV exposures that warrant PEP, a basic 4-week, two-drug (there are several options) regimen is recommended. For HIV exposures that pose an increased risk of transmission (based on the infection status of the source and the type of exposure), a three-drug regimen may be recommended. Special circumstances, such as a delayed exposure report, unknown source person, pregnancy in the exposed person, resistance of the source virus to antiviral agents, and toxicity of PEP regimens, are also discussed in the guidelines. Occupational exposures should be considered urgent medical concerns.

**Building Better Prevention Programs for Health Care Workers**

Continued diligence in the following areas is needed to help reduce the risk of occupational HIV transmission to health care workers.

**Administrative efforts.** All health care organizations should train health care workers in infection control procedures and on the

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importance of reporting occupational exposures. They should develop a system to monitor reporting and management of occupational exposures.

Development and promotion of safety devices. Effective and competitively priced devices engineered to prevent sharps injuries should continue to be developed for health care workers who frequently come into contact with potentially HIV-infected blood and other body fluids. Proper and consistent use of such safety devices should be continuously evaluated.

Monitoring the effects of PEP. Data on the safety and acceptability of different regimens of PEP, particularly those regimens that include new antiretroviral agents, should be continuously monitored and evaluated. Furthermore, improved communication about possible side effects before starting treatment and close follow-up of health care workers receiving treatment are needed to increase compliance with the PEP.