

Utah Department of Health
Bureau of Epidemiology
Prevention, Treatment and Care Program

HIV Integrated Epidemiological Profile
2015

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Data Notes

Data used for this report included HIV surveillance data from the enhanced HIV/AIDS Reporting System (eHARS), UT-NEDSS electronic surveillance system, CareWare (Ryan White Part B), Utah Violent Death Reporting System, and IBIS-PH (Utah's Public Health Indicator Based Information System).

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Definitions

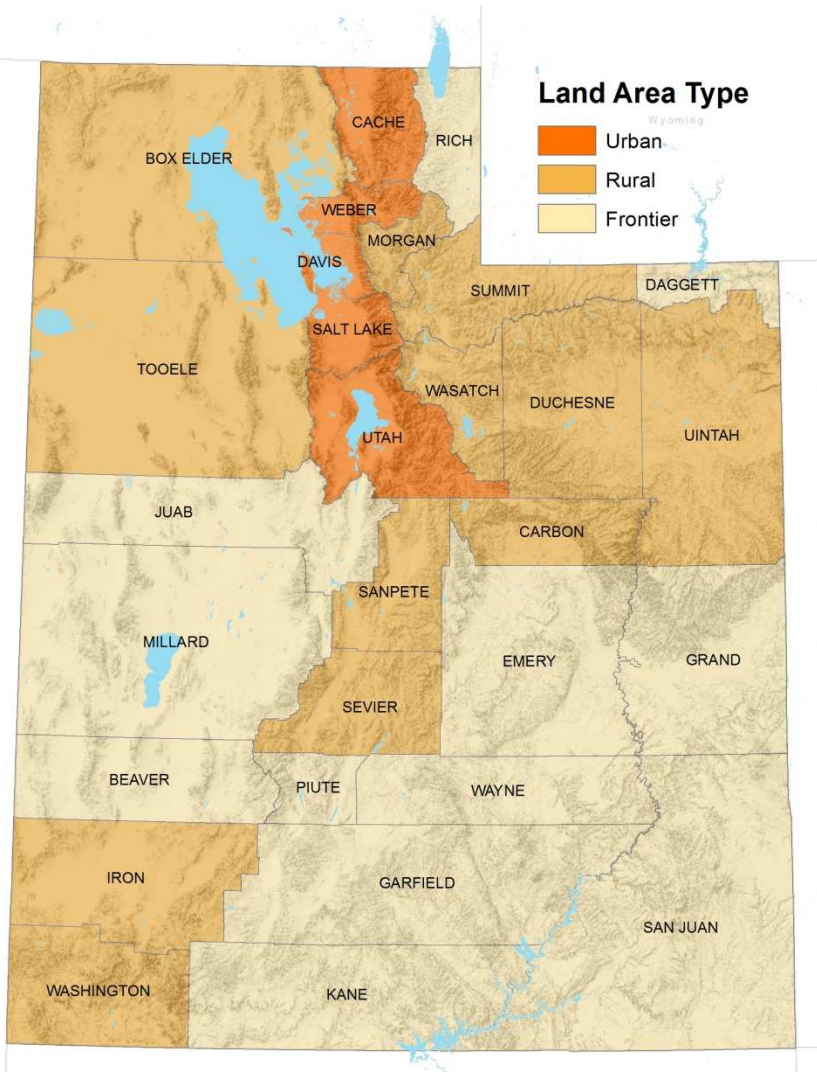
- **Land area classification** – Classification according to population density: urban, rural, and frontier.
- **Surveillance data** – Diagnosed and reported infections of HIV/AIDS
- **Rates** – Infections per 100,000 population
- **Age** – Age at time of HIV diagnosis
- **Sex** – Sex at birth
- **Gender** – Current self-identified gender
- **Risk category** – HIV risk identified at diagnosis
- **MSM** – Men who have sex with men
- **IDU** – Injection drug use
- **Local Health District** – Utah’s 29 counties are organized into 13 local health districts
- **New HIV diagnoses** – HIV cases diagnosed within the past year in Utah
- **Prevalent HIV infections** – HIV cases currently living in Utah
- **HIV infection** – Infected with HIV
- **HIV (not AIDS)** – A case of HIV infection that has never been diagnosed with an AIDS-defining illness or had a CD4 count ≤ 200 cell/ μ L
- **AIDS** – Acquired Immunodeficiency Syndrome
- **PLWHA** – People living with HIV/AIDS
- **Ever-in-Care** – Individual diagnosed with HIV, who has had at least one CD4, VL, or genotype sequence reported
- **Linked-to-Care** – Newly diagnosed HIV case that has had a CD4, VL, or genotype sequence performed in the assessment period
- **Currently-in-Care** – Individual diagnosed with HIV who was previously determined to be linked-to-care and has had at least one CD4, VL, or genotype sequence in the past year.
- **Retained-in-Care** – Individual diagnosed with HIV who was previously determined to be linked-to-care and had two CD4, VLs, or sequence genotype at least 90 days apart
- **NIR** – No Identified Risk

Utah Geography and Population Densities

The state of Utah is a large area state of about 84,900 square miles found in the western United States of America. Utah is defined by its vast expanses of deserts, plateaus, and mountain ranges. Utah contains many rivers, streams, reservoirs, and lakes, such as the Great Salt Lake, which is the second largest body of inland water in the world and has a higher salinity than the ocean. Utah is also home to beautiful and diverse landscapes, including numerous national and state parks and monuments that visitors from around the world come to see every year.

The geography and vastness of Utah has kept the majority of people living in Utah to specific areas within the state. The Wasatch Front is a region that lies at the foothills of the Wasatch Mountain range stretching for 120 miles. The Wasatch Front is comprised of four counties (Weber, Davis, Salt Lake, and Utah) where 76% of the entire population of Utah resides.

In 2015, an estimated 2,995,919 people were living in Utah. Utah is categorized into three (3) land area definitions according to population density: urban, rural, and frontier.¹ Urban areas are defined as containing 100 or more people per square mile, rural areas are those less than 100 but more than 6 people per square mile, and frontier is 6 or fewer people per square mile. As of 2015, there were five counties classified as urban, 12 counties as rural, and 12 counties as frontier.



¹ Definitions of population densities for frontier, rural, and urban are defined by the Office of Vital Records and Statistics, Utah Department of Health

Newly Diagnosed HIV Infections in Utah

Background

The human immunodeficiency virus (HIV) is a lentivirus that specifically infects humans and affects the immune system. Over time, infection with HIV may lead to a diagnosis of acquired immunodeficiency syndrome or AIDS, which can result in death if untreated. HIV was identified more than 30 years ago. Since that time, unprecedented research and public health efforts around the world have reduced deaths caused by HIV. Testing technology for rapid and accurate diagnosis has rapidly evolved, which has reduced the time to detection of the virus after initial infection from 90 days to as soon as 10 days. Many antiviral agents have been developed and tested and, due to global public health efforts, access to these medications has rapidly increased, even in developing countries. All of these efforts have changed the face of the epidemic. Early detection and treatment of HIV is resulting in greatly increased life expectancies for HIV patients. In addition, because HIV-infected persons on treatment with undetectable viral loads have a greatly reduced risk of transmitting HIV, early diagnosis and linkage to HIV care and treatment services are high priorities for reducing the spread of HIV.

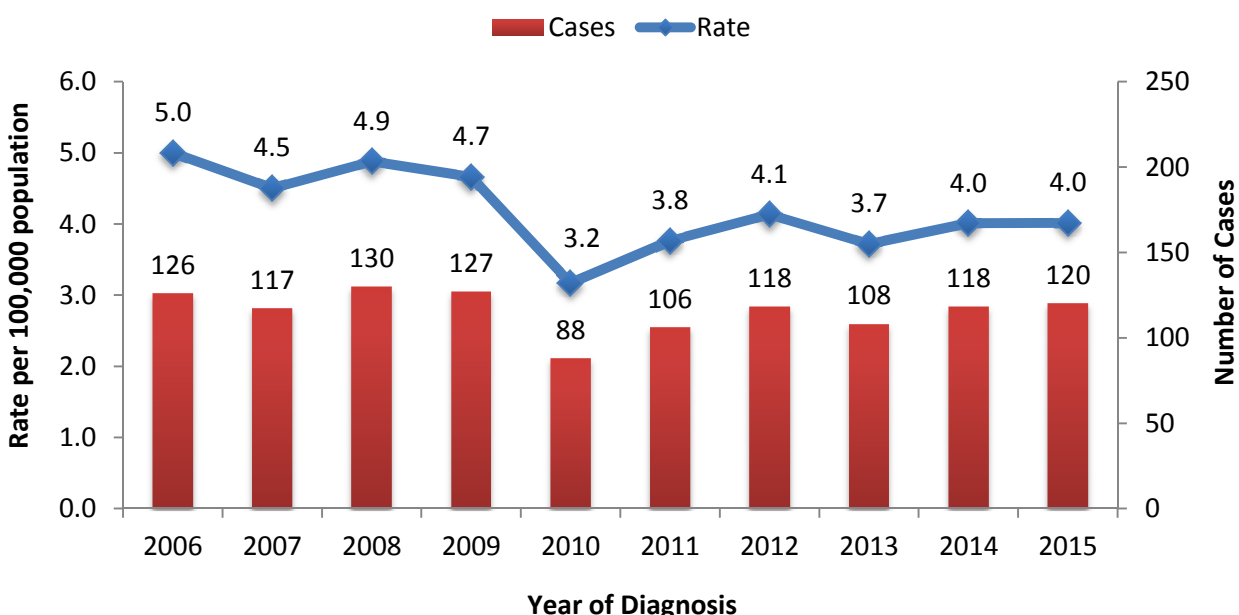
HIV infection continues to affect communities throughout Utah every year. The Utah Department of Health (UDOH) collaborates with local health departments (LHDs), clinical providers, community-based organizations, and laboratories to identify newly diagnosed infections of HIV through testing and disease reporting. When a newly diagnosed infection of HIV is reported, local health departments work quickly to obtain basic demographic and risk information, provide education regarding the infection, and discuss how the infection may have been acquired and who else might have been exposed. The infected individual is also linked to a medical provider for care and treatment services. Understanding who becomes infected with HIV and how they became infected provides public health programs with the necessary knowledge to direct resources to the individuals and communities most likely to be affected, in a continued effort to reduce new infections.

New HIV Diagnoses

Reporting of HIV and AIDS cases began in the early 1980s in Utah, resulting in several hundred cases diagnosed each subsequent year. The largest number of newly diagnosed HIV infections was reported in 1990 at 293 cases for a rate of 16.9 per 100,000 population. Since then, newly diagnosed infections have continued to decrease in Utah and now remain relatively stable; however, new infections of HIV continue to be diagnosed and reported in Utah every year. Between 2006 and 2010, the rate of newly diagnosed HIV infections in Utah decreased from 5.0 per 100,000 population to 3.2 per 100,000 population. Since then rates have fluctuated slightly but have mostly remained stable. In 2015, there were 120 new HIV infections diagnosed for a rate of 4.0 cases per 100,000 population.

It is important to note that individuals can be infected with HIV for several years before they are diagnosed. A person infected with HIV typically does not show signs or symptoms for many years and, therefore, the infection can remain undetected. Symptoms of HIV infection can vary depending on many factors, such as general health and other conditions, but typically do not appear in the early years of infection. Therefore, counts and rates of new HIV diagnoses may not accurately represent incidence (i.e., actual newly acquired HIV infections in a specific year).

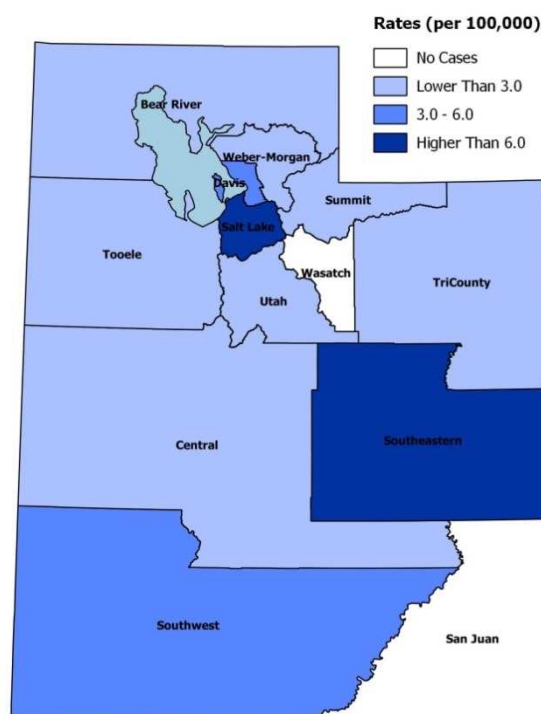
Cases and Rates of New HIV Diagnoses —Utah, 2006-2015

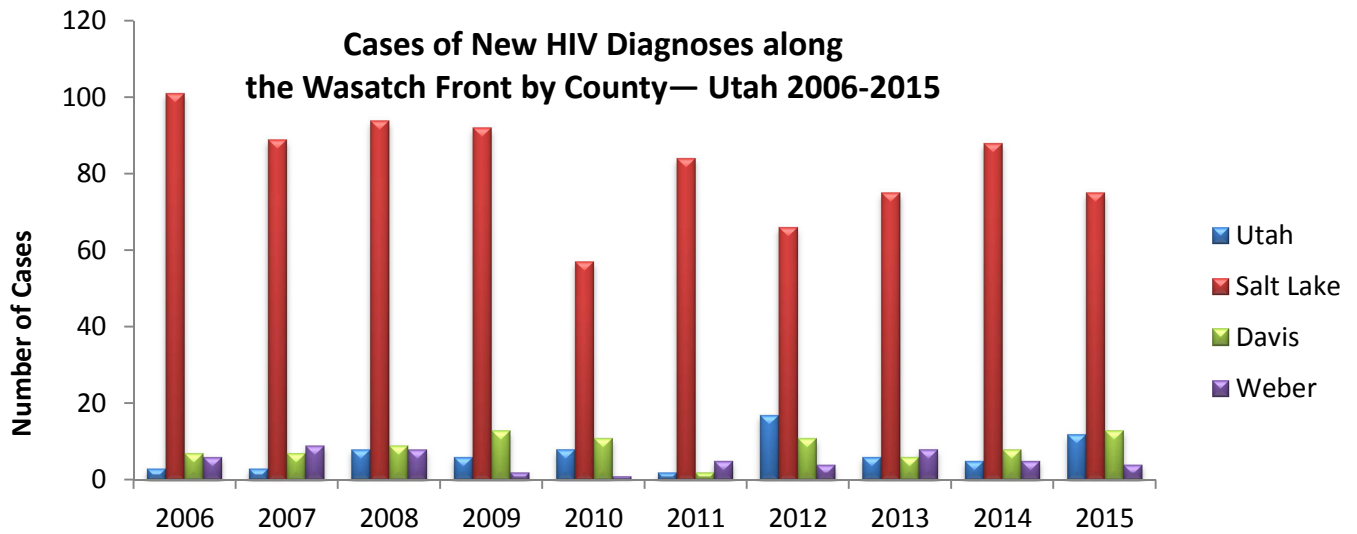


Location of New HIV Diagnoses

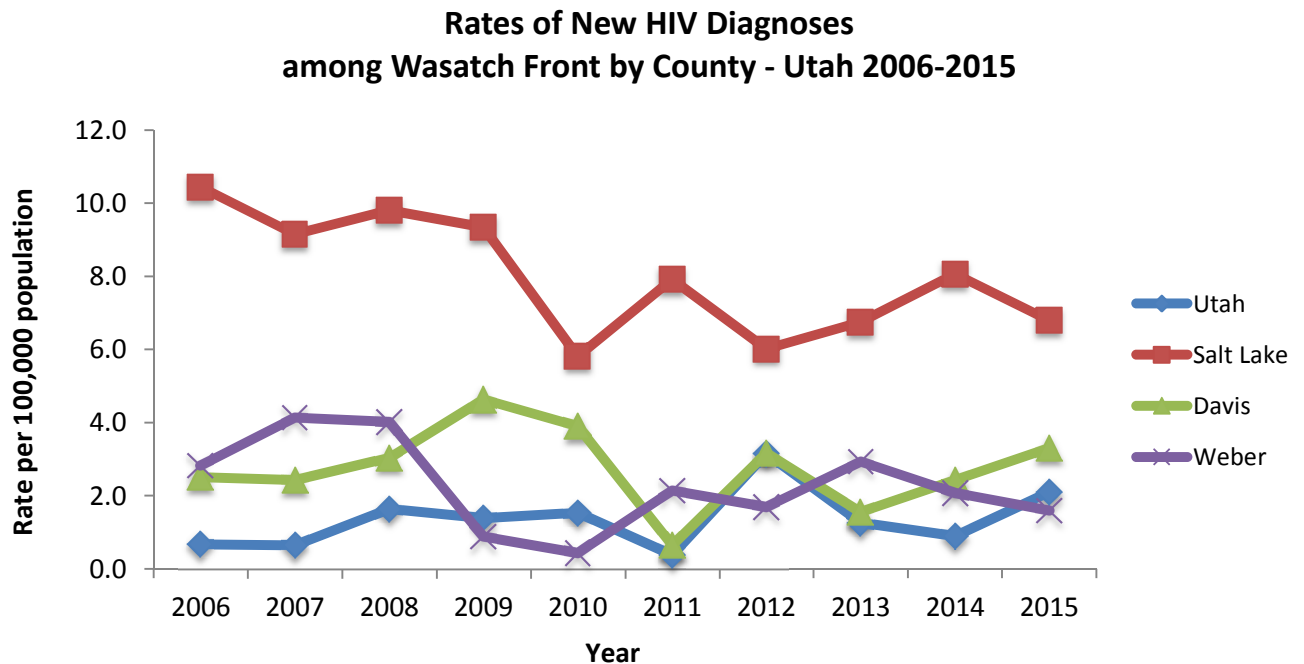
Utah consists of 29 counties that make up 13 local health districts. Each health district may consist of a single county or several counties. While county governments may differ, each local health district manages and coordinates public health activities within the district. Most of the newly diagnosed HIV cases are reported along the Wasatch Front (Weber, Davis, Salt Lake, and Utah counties) with the majority from Salt Lake County. In 2015, 85% of newly diagnosed HIV infections resided within the Wasatch Front; 63% of newly diagnosed HIV infections resided in Salt Lake County. Over the past 10 years, reported infections in Salt Lake County have fluctuated, ranging from 101 infections in 2006, to 57 infections in 2010, to 75 infections in 2015. The other counties along the Wasatch Front have remained relatively stable. Utah County reported 17 infections in 2012, which was the highest reported number of cases reported by a LHD other than Salt Lake County in the past decade.

New HIV Diagnoses Rates (per 100,000) by Local Health District—Utah, 2015





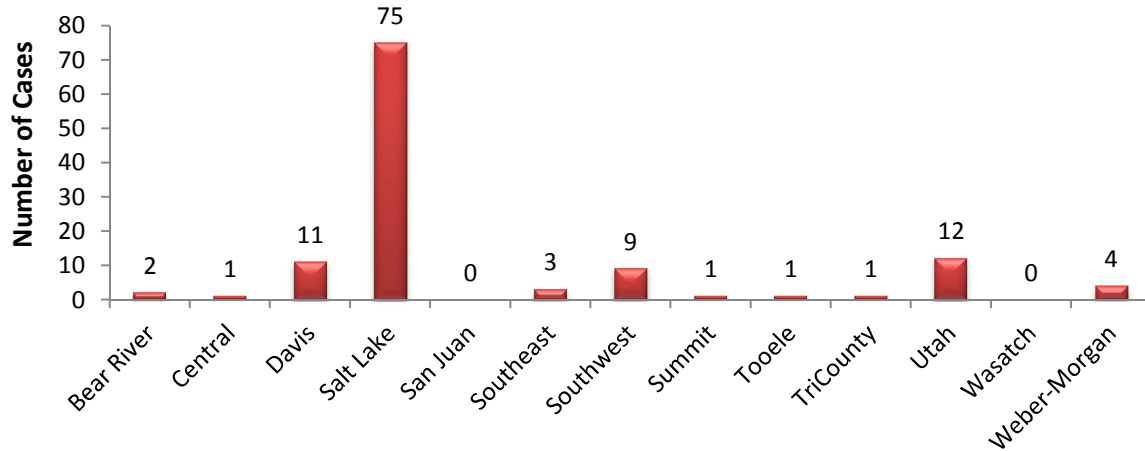
Trends in rates of new HIV diagnoses continue to be monitored along the Wasatch Front. While rates in each county have remained stable over the last decade, rates often fluctuate from year to year. Salt Lake County, while observing the highest rates, has decreased from 2006 through 2015. These decreased rates in Salt Lake County have driven the overall statewide decrease as the remaining counties continue to report stable numbers.



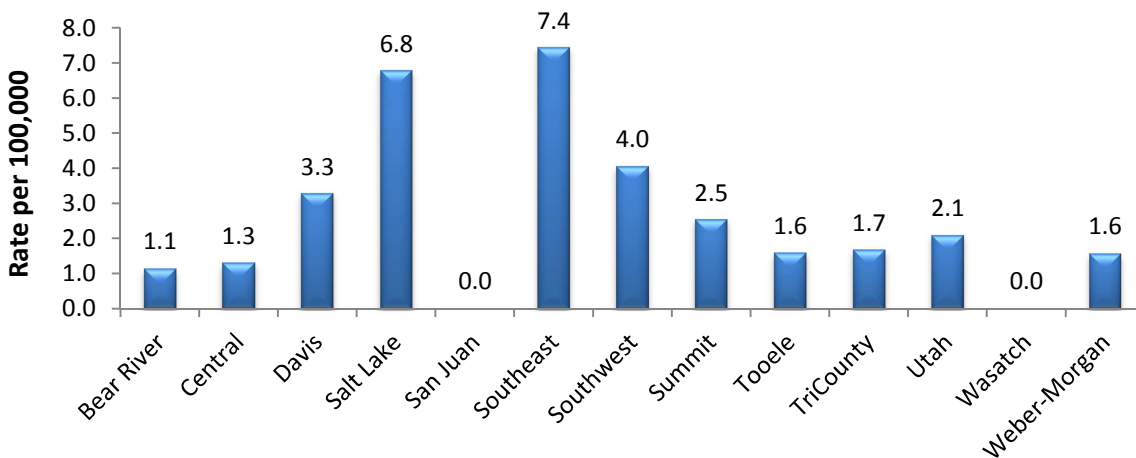
Outside the Wasatch Front, the Southwest Public Health District in southwestern Utah has seen higher rates of new HIV diagnoses compared with other districts. However, the number of cases is small and rates may fluctuate from year to year. In 2015, there were nine cases of newly diagnosed HIV infection reported in the district for a rate of 4.0 cases per 100,000 population. Therefore, while Southwest only accounted for 7.5% of the new HIV diagnoses in Utah during 2015, it had the third highest rate in the state.

There were three new HIV cases diagnosed and reported during 2015 in the Southeast Utah Public Health District. As this district is primarily frontier, the low population resulted in an elevated rate of 7.4 infections per 100,000 population. The remaining districts continue to report a new diagnosis or two each year. As they continue to experience low numbers of cases, specific trends have been inconsistent.

Number of New HIV Diagnoses by Local Health District - Utah, 2015



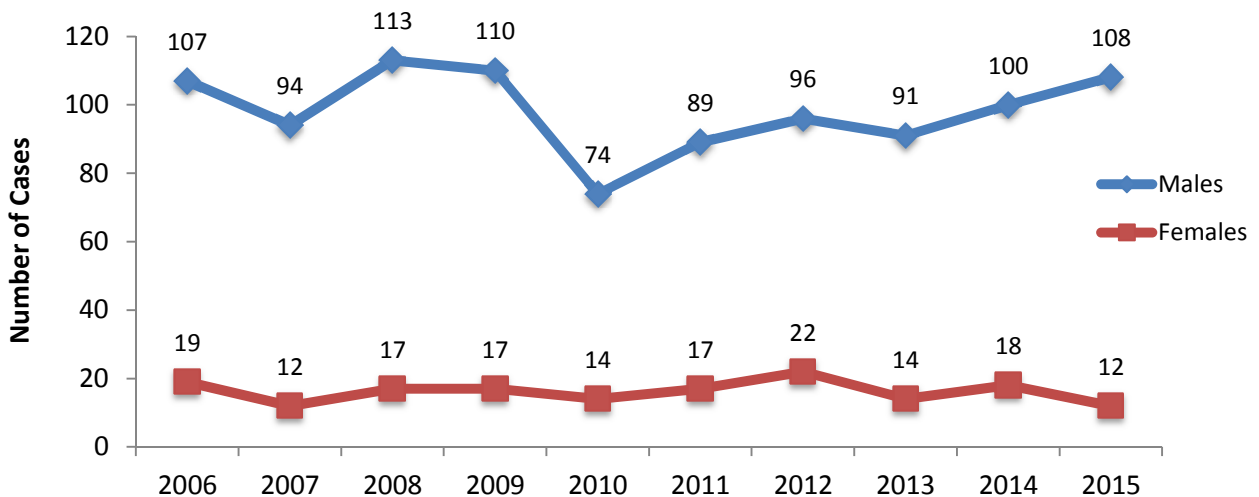
Rates (per 100,000) of New HIV Diagnoses by Local Health District - Utah, 2015



Age and Sex of New HIV Diagnoses

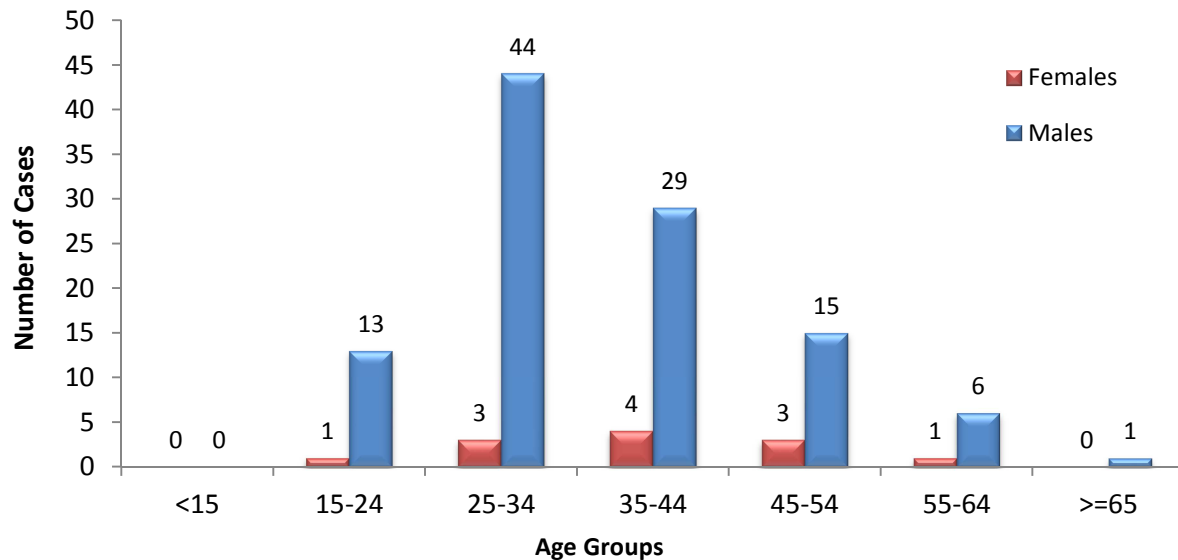
New HIV diagnoses disproportionately affect males in Utah every year. From 2006-2015, males accounted for 85% of new HIV diagnoses and this proportion remained relatively stable during this period. Over the past 10 years, the number of newly diagnosed HIV infections in both males and females has slightly fluctuated, but only males have experienced an upward trend in recent years. The highest number of new HIV diagnoses in males was reported in 2008 with 113 cases; however, in 2010, that number dropped to 74 cases. Since 2010, the number of new HIV diagnoses has continued to increase overall among males. In 2015, there were 108 new HIV diagnoses reported, the highest number since 2009. Although much lower in number, reports of newly diagnosed HIV cases among females have remained relatively stable over the past 10 years with the highest number reported in 2007 at 23 cases. In 2015, only 12 new HIV diagnoses were reported among females.

**Number of New HIV Infections by Sex -
Utah, 2006-2015**



HIV infection can affect individuals of all ages. However, each year, HIV cases diagnosed and reported in children (defined as <13 years of age) and those 65 or older are few in number. Adult males ages 25-34 years of age are primarily affected more than other age groups. In 2015, males ages 25-34 and 35-44 experienced the largest burden of disease. While rates in these age groups have fluctuated over the last 10 years, the rate of new infections diagnosed among 25-34 year-old men has steadily increased since 2010. Other age groups for males have decreased or remained relatively stable during this time period. The majority of new HIV diagnoses are consistently in males ages 15-44 years of age. Females are typically diagnosed at older ages than males, but Utah's low incidence prevents visible trends among females by age group.

Number of New HIV Infections by Sex and Age Group - Utah, 2015

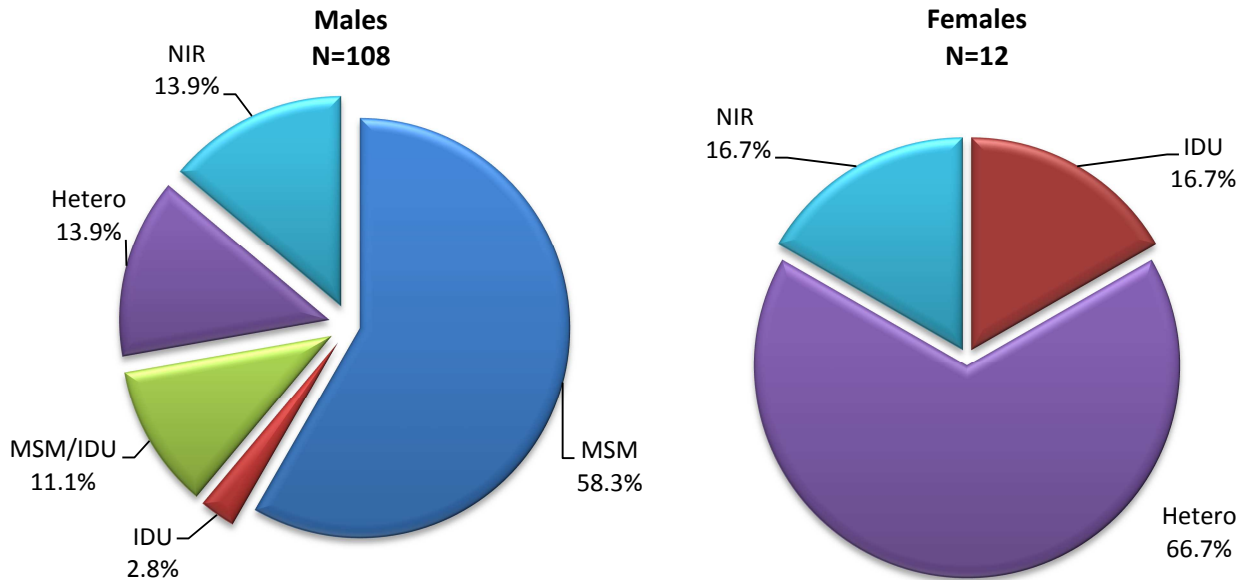


Risk Categories among New HIV Diagnoses

Each newly diagnosed and reported case of HIV infection is assessed for risk factors to determine how the virus was spread. A risk category is then assigned to the case as the most likely way the person acquired HIV. Risk categories are defined by the CDC and include: men who have sex with men (MSM), high risk heterosexual contact, injection drug use (IDU), men who have sex with men and inject drugs (MSM/IDU), mother-to-child transmission, and cases who received a transfusion or plasma product. Risk categories can be difficult to ascertain as individuals may not know how they acquired HIV or be unwilling to divulge sensitive information. However, it is important to obtain this information to enable programs to direct interventions to effectively prevent HIV transmission in Utah. Persons who cannot identify their risk or are not thoroughly interviewed are categorized as no identified risk (NIR).

Risk categories vary significantly by sex. In 2015, 58.3% of males were categorized as MSM, followed by NIR at 13.9%, heterosexual risk at 13.9%, MSM/IDU at 11.1%, and IDU at 2.8%. For females diagnosed with HIV in 2015, 66.7% were categorized as heterosexual risk, 16.7% as IDU, and 16.7% as NIR.

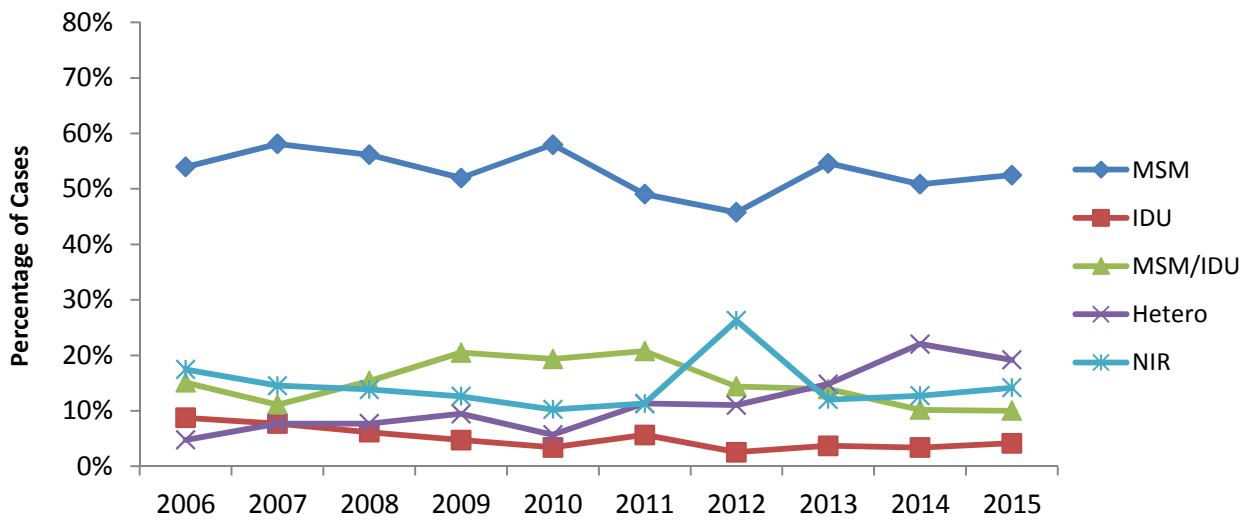
Percentage of New HIV Diagnoses by Risk Category and Sex— Utah, 2015



Monitoring these trends over the last 10 years shows how MSM have been primarily affected by HIV infection. The percentage reporting MSM has remained stable, however, the percentage reporting a combined risk of MSM and IDU has steadily decreased over the last five years. Trends among the risk categories have remained relatively stable; risks such as IDU and heterosexual contact have continued to remain low. However, increased efforts to collect data on risk may have contributed to a steady increase in reported heterosexual contact as a risk factor over the last five years.

In 2011, the percentage of cases with missing risk information began to increase slightly after several years of decline. In 2010, only 10% of newly diagnosed infections were classified as NIR; by 2012, this percentage increased to 26%. In 2013, the issue was brought to the attention of the local health departments to see whether they could improve interviewing techniques. In addition, other data sources such as Ryan White and HIV prevention program data have been utilized to ascertain risk information. The result was a reduction in missing risk factor information to only 14% for both males and females in 2015. UDOH will continue these efforts to further prevent missing risk factor information. One observation is that the missing data seems to be inversely correlated to MSM, suggesting the population where difficulty in collecting risk factor data has occurred may be among MSM. For each of those years where rates of missing risk data increased, rates of reported MSM risk decreased, and vice-versa. UDOH will continue to monitor and discuss this trend.

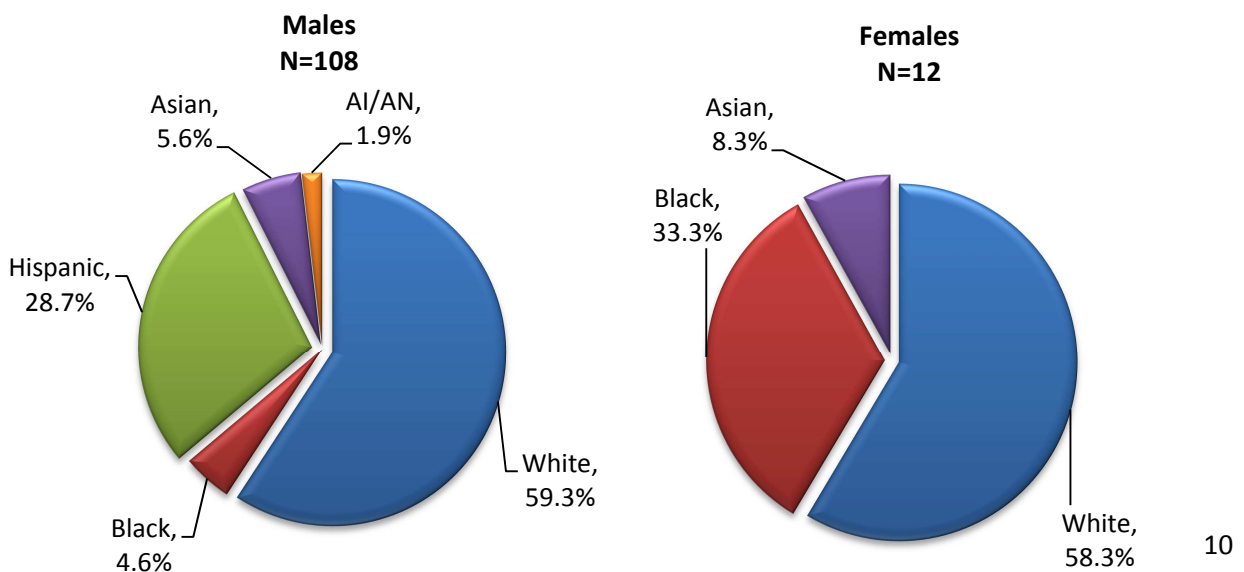
Percentage of New HIV Diagnoses by Risk Category - Utah, 2006-2015



Race and Ethnicity

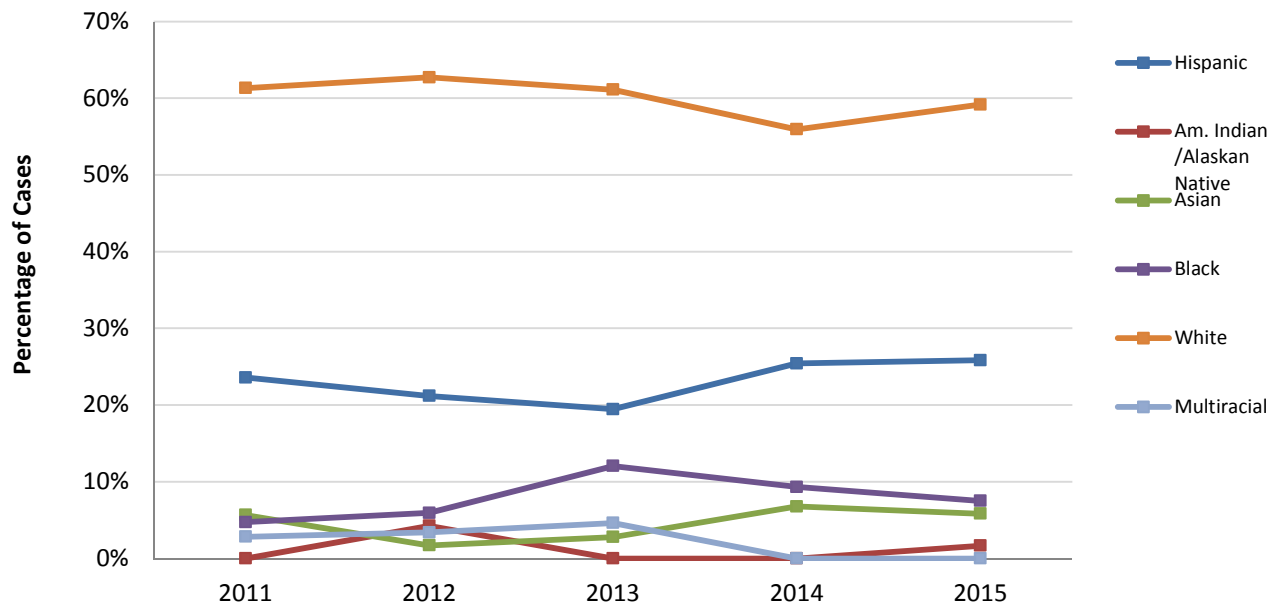
In 2015, 59.2% (71 cases) of new HIV diagnoses reported in Utah were among white, non-Hispanic individuals followed by Hispanics at 25.8% (31 cases). Among men, 59.3% (64 cases) of new HIV cases were reported as white, non-Hispanic; followed by Hispanic at 28.7% (31 cases); Asian, non-Hispanic at 5.6% (6 cases); black, non-Hispanic at 4.6% (5 cases); and American Indian/Alaskan Native (AI/AN) at 1.9%. Compared with men, a higher percentage of cases were reported in black, non-Hispanic women (33%, 4 cases) and Asian, non-Hispanic women (8.3%, 1 case). White, non-Hispanic women were fairly proportionate to the men at 58.3% (7 cases). Only 29 Hispanic women have been diagnosed with HIV in Utah in the last 10 years; no Hispanic women were diagnosed with HIV in 2015.

Percentage of New HIV Diagnoses by Race/Ethnicity and Sex— Utah, 2015



The percentage of cases among non-Hispanic whites and Hispanics, accounting for the majority of cases, has remained relatively stable over the last few years. Despite low case counts, the highest rates of HIV infection are experienced by black, non-Hispanic men and women in Utah. While the population of black, non-Hispanics in Utah is comparatively small, this population is disproportionately affected by HIV. Rates among this population are consistently the highest reported in Utah, however, fluctuations do occur. Over the last decade, the rate of new HIV diagnoses in black women has steadily declined. Black males, on the other hand, experienced increases in new HIV diagnoses beginning in 2012. The number of Asian males newly diagnosed with HIV has also increased in recent years beginning in 2013. While these populations account for few cases, trends in rates will be monitored to ensure efforts are made to reduce the disproportionate burden experienced by these groups.

Percentage of New Diagnoses by Race/Ethnicity - Utah, 2011-2015

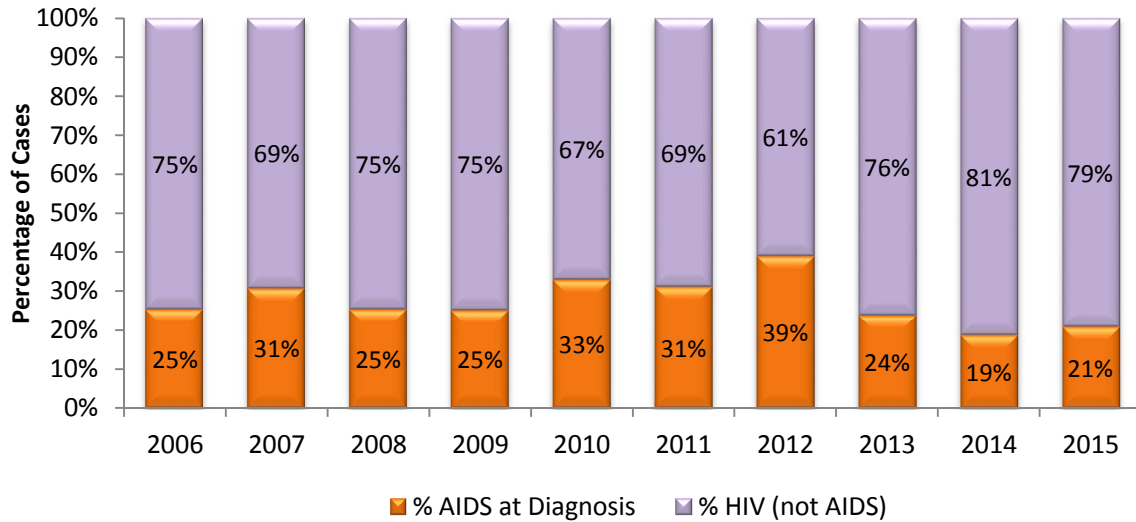


AIDS at HIV Diagnosis

Having progressed to AIDS at HIV diagnosis is an indication of late testing for HIV. Ideally, individuals who become infected with HIV should be tested and notified of their serostatus shortly after infection so they can be linked to care and treatment services early in the course of illness to prevent progression to AIDS. In addition, people who are unaware of their HIV infection status are more likely to continue to spread HIV and experience worse health outcomes.

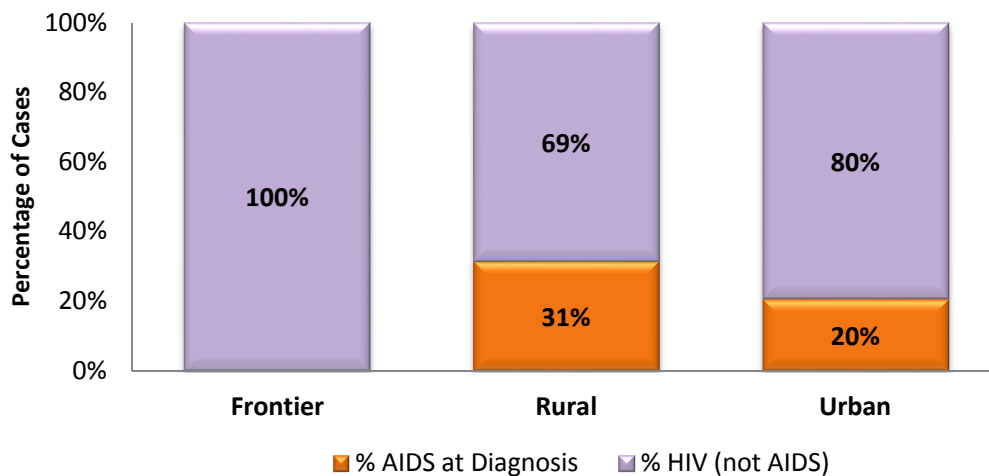
Monitoring trends in AIDS at HIV diagnosis over time provides an indication of how well programs are doing in detecting cases earlier. In 2015, only 21% of those newly diagnosed with HIV had AIDS at diagnosis. However, looking at this percentage in another way, 1 in 5 newly diagnosed HIV cases were not found early enough to prevent progression to AIDS. In the last few years, rates of late diagnoses have remained stable and low. In 2007 and from 2010 through 2012, the rate of AIDS at diagnosis was above 30%. In the last decade, the highest rate was reported in 2012 at 39% while the lowest rate was reported in 2014 at 19%.

**Percentage of New HIV Diagnoses with and without AIDS at
Diagnosis—Utah, 2006-2015**



Access to HIV testing and health care in general may be affected by several barriers. Persons living in rural communities may be more likely to be tested late in the course of illness and may also have less access to care and treatment services. In 2015, 31% of newly diagnosed HIV cases residing in rural counties had AIDS at the time of diagnosis compared with 20% in urban areas. While this is not a statistically significant difference, it may indicate limited access to HIV testing services or limited awareness of HIV risk in rural communities. Interestingly, the few cases diagnosed in a frontier county were all tested early and consequently were not diagnosed with AIDS. Targeted testing efforts should be considered in rural and frontier areas.

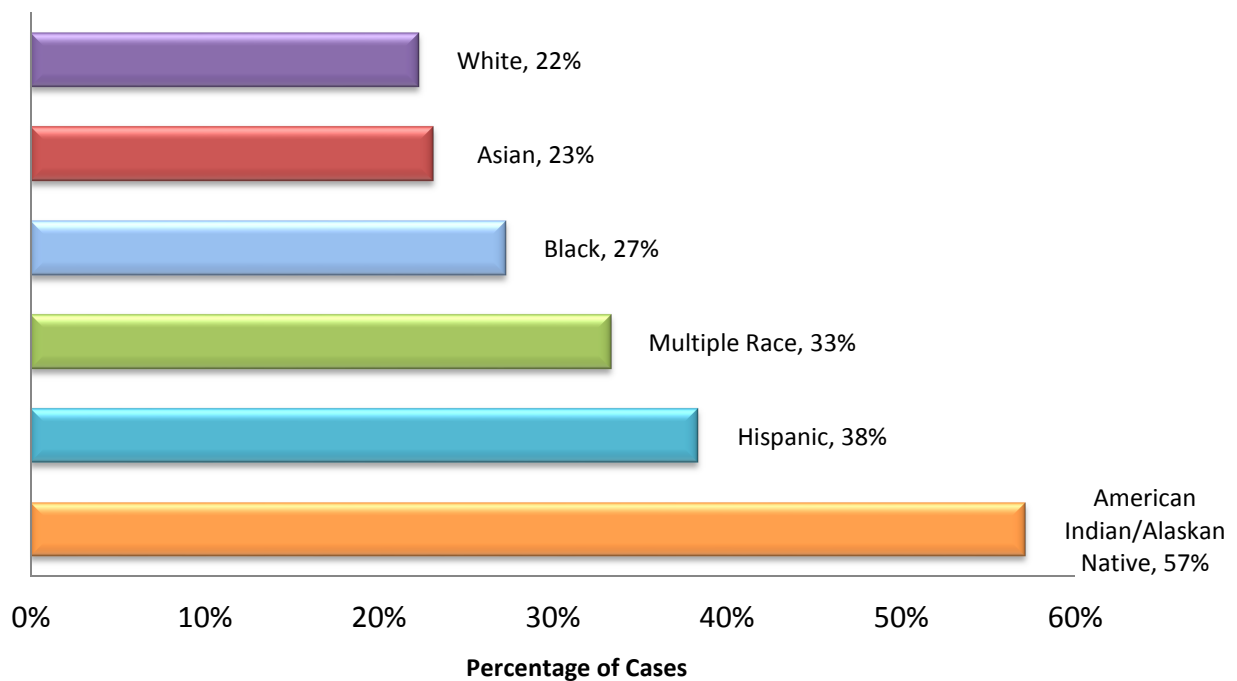
**Percentage of New HIV Diagnoses with and without AIDS at the
Time of Diagnosis by Population Density— Utah, 2015**



Race and ethnicity may also contribute to the early detection of HIV. From 2011-2015, those diagnosed with AIDS at the time of their HIV diagnosis were more likely to be among a racial or ethnic minority group. During this five-year period, only 22% of White non-Hispanics had an AIDS diagnosis at the time of their HIV diagnosis while 38% of Hispanics were diagnosed with AIDS at HIV diagnosis. Other groups such as Native Hawaiians/Pacific Islanders (not included in the chart below) and American Indians/Alaskan Natives had very low numbers of infections during this time period; however, at least half of them had already progressed to AIDS at the time of their HIV diagnosis. Fewer than one-third of non-Hispanic Asian, non-Hispanic black, and non-Hispanic multi-race (23%, 27%, and 33% respectively) HIV diagnoses were classified as having AIDS at diagnosis.

Further studies are needed to understand why certain racial and ethnic groups are less likely to receive an HIV diagnosis early in the course of illness.

**Percent of New HIV Diagnoses with AIDS at Diagnosis
by Race/Ethnicity - Utah, 2011-2015**



People Living with HIV/AIDS in Utah

Each year in Utah, people who live throughout the state are newly diagnosed with HIV. Additionally, people who have been previously diagnosed with HIV in another state or jurisdiction move to Utah. Similarly, persons diagnosed with HIV in Utah may move to another state at some point after their diagnosis. Monitoring the total number of persons with HIV who are currently living in Utah, regardless of where they were diagnosed (referred to as the prevalence of HIV in Utah), is essential to understanding the quantity of care and treatment services needed. Additionally, it is vital to identifying high prevalence geographic areas and populations that should be prioritized for prevention interventions.

A major goal of health departments and community partners is reducing the community viral load by achieving viral suppression within each individual. With better access to health care and antiretroviral medications, people infected with HIV are living much longer and with improved quality of life than in previous years. UDOH strives to increase the percentage of PLWHV who are virally suppressed by monitoring the care of this population and promoting efficient linkage and retention to HIV treatment and care services.

The number of people living with HIV is determined through various methods and criteria. People diagnosed with HIV are reported to public health in Utah either by laboratory or clinician reporting. Diagnostic laboratory results along with lab results related to HIV care and treatment are both reportable to UDOH.

Utah, in collaboration with the CDC and other jurisdictions, makes every effort to prevent cases from being counted twice. State health departments perform confidential name-based searches as well as de-duplication efforts to ensure the record of a person who has moved is updated with their new address. These efforts allow UDOH to accurately measure the number of PLWHA in Utah and are also vital for ensuring that people who move are linked to care in their new state of residence.

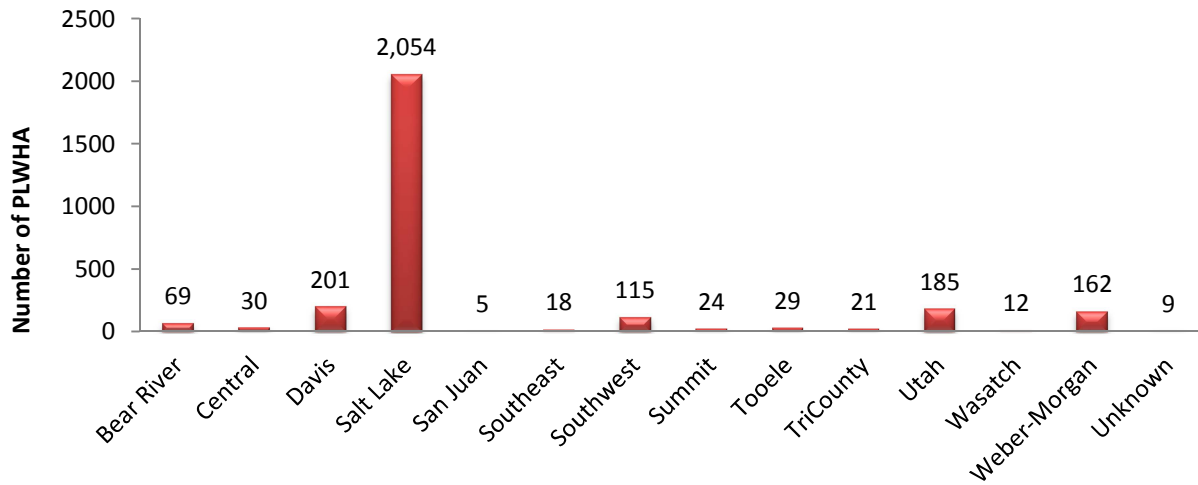
UDOH collaborates with the Office of Vital Records and Statistics to determine whether people living with HIV in Utah have died. National death records also assist in this effort. These activities are crucial for calculating the number of people living with HIV in Utah but, unfortunately, take time to conduct. Therefore, to accurately assess this figure in this report, the number of people living with HIV is defined as those who were reported to public health by December 31, 2014 and were not found to have died or moved to another state during 2015. All death and address data collected during 2015 was used to determine how many diagnosed cases were considered to be living in Utah with HIV on December 31, 2015.

In 2015, there were 120 newly diagnosed HIV infections reported to UDOH and 2,934 people were considered to be living in Utah with HIV on December 31, 2015. Compared with other states and jurisdictions, the number of persons living with HIV in Utah is still considered to be fairly low. Overall, Utah seems to increase by roughly a thousand people living with HIV each decade. UDOH, LHDs, and community partners continue to strive to reverse this trend through HIV prevention efforts.

Location of People Living with HIV/AIDS

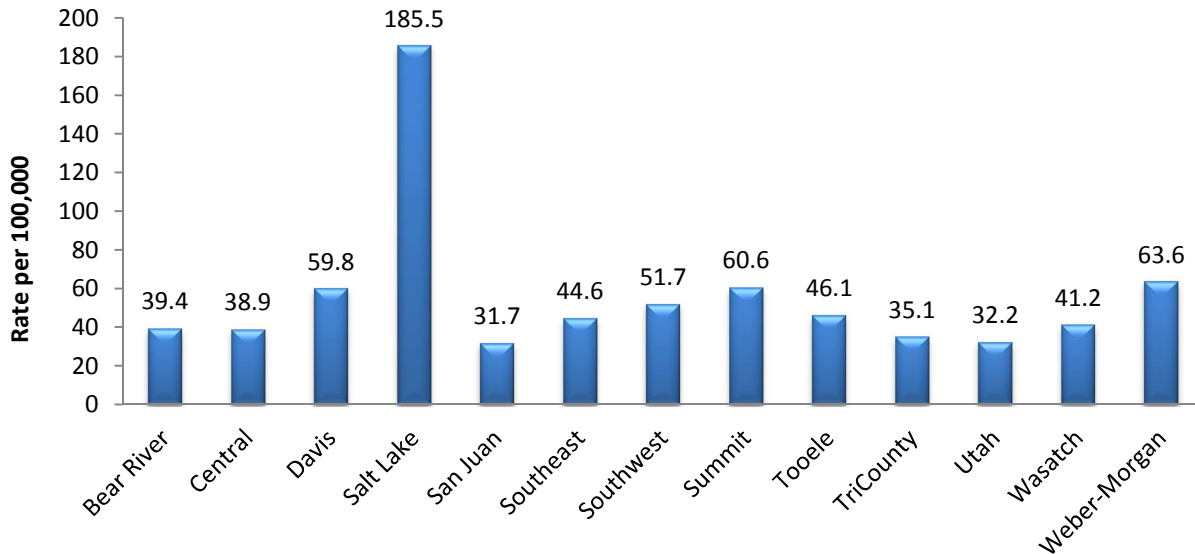
Of those with a known LHD of residence, the majority (70%) of PLWHA in Utah reside in Salt Lake County and 88.6% reside along the Wasatch Front (Weber, Davis, Salt Lake, and Utah counties). However, every LHD in Utah has some PLWHA and only 3 counties (Piute, Beaver, and Daggett) have not reported a case of HIV infection as of the end of 2015.

Number of People Living with HIV/AIDS by Local Health District - Utah, 2015



Salt Lake County had the highest prevalence rate of PLWHA at the end of 2015 at 185.5 infections per 100,000 population followed by Weber-Morgan Health District at 63.6 infections per 100,000 population. San Juan Health District reported the lowest prevalence rate of 31.7 infections per 100,000 population. It is important to consider the prevalence rate by LHD when allocating testing, care, and treatment resources.

Rates (per 100,000) for People Living with HIV/AIDS by Local Health District - Utah, 2015

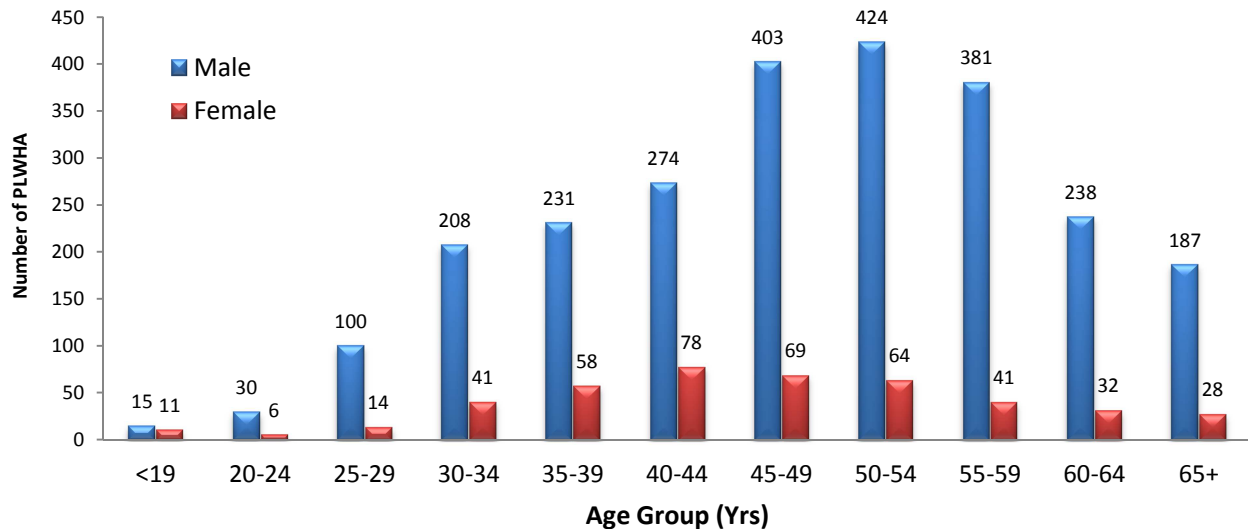


Age and Sex of People Living with HIV/AIDS

Males in Utah continue to be disproportionately affected by HIV infection than females. As of December 31, 2015, males accounted for 85% of PLWHA in Utah. Males between the ages of 45 to 59 years old accounted for the highest number of infections at 48% of the males living with HIV. Among females living with HIV, the infection is more evenly distributed among the various age groups.

This age distribution can be explained by the fact that the largest number of HIV infections were diagnosed 20-30 years ago, before HIV prevention efforts were fully developed. Many of these persons were able to access medications and continue to live. Therefore, each year the largest age group of men living with HIV gets older. In contrast, new HIV diagnoses are more frequently among younger males.

**Number of People Living with HIV/AIDS
by Sex and Age Group— Utah, 2015**

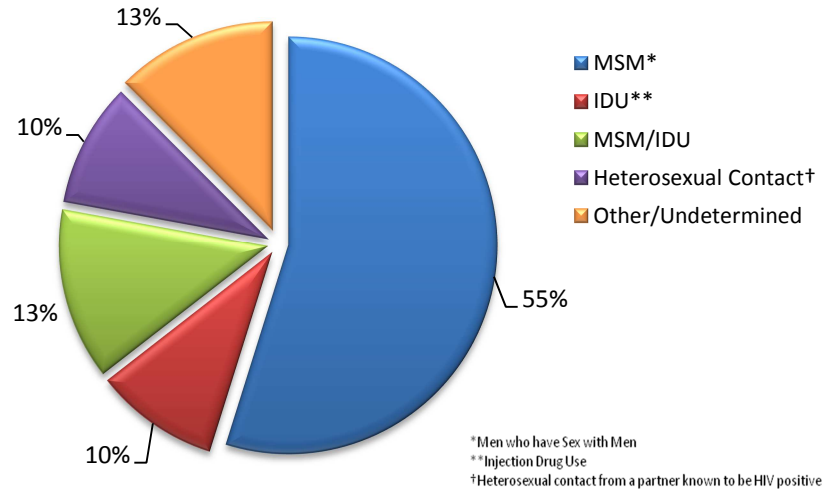


Among adolescents and children known to be living in Utah with HIV, none of them were born or diagnosed in Utah. In other words, Utah has not identified a case of mother-to-child transmission of HIV for many years. This attests to the success of programs to prevent mother-to-child transmission in Utah. Children living with HIV in Utah (26 infections, 0.9% of PLWHA) have typically moved to the state from an area in the United States with a high prevalence of HIV or another country. Utah continues to successfully monitor mothers with HIV and, as a result, has been successful in reducing the risk of transmission.

Risk Category among PLWHA

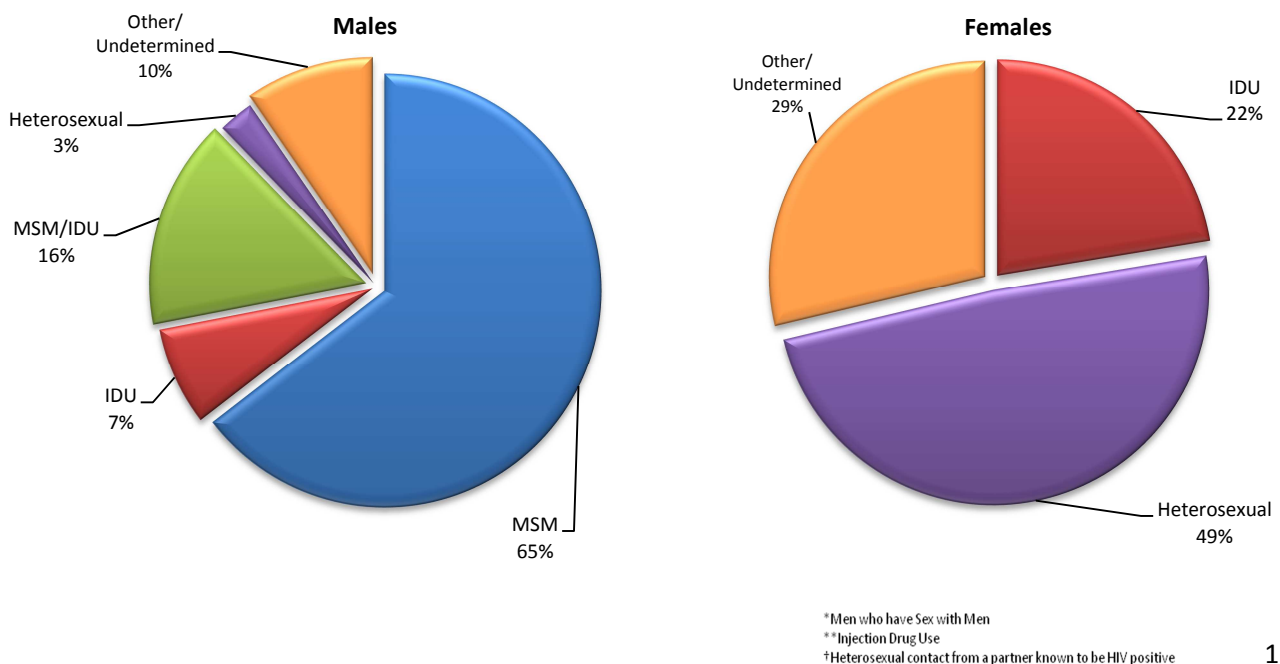
PLWHA in Utah are more varied by risk category than newly diagnosed infections. MSM continues to be the highest risk reported (55%) followed by MSM/IDU (13%). Risk that is undetermined or historical, such as blood transfusions, accounts for 13% of the population; 10% of those living with HIV report injection drug use as their risk factor and likewise 10% report high-risk heterosexual contact. HIV risk is assessed at the time of diagnosis or when the individual is reported to public health. It is recognized that risk behaviors may change over time and data on current risk factors is not available.

Percentage of People Living with HIV/AIDS by Risk Category— Utah, 2015



Risk categories vary by sex and ascertainment of risk categories is higher for men than for women. Among men, only 10% have undetermined or historical risks, while undetermined or historical risk is the risk category for 29% of women living with HIV. Females are also at higher risk of identifying as IDU (22%) than males (7%).

Percentage of People Living with HIV/AIDS by Risk Category and Sex— Utah, 2015



Race and Ethnicity among PLWHA

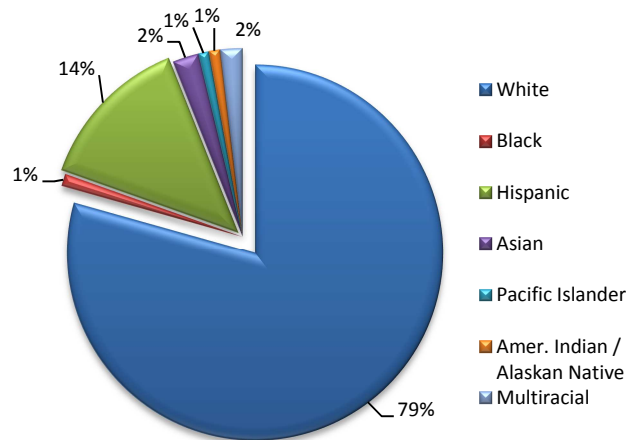
Utah, while growing in racial and ethnic diversity in recent years, is primarily made up of white, non-Hispanic persons. Only 21% of Utah's population are among minority populations. The largest population other than White non-Hispanics are Hispanics. The Hispanic population made up an estimated 14% of Utah's population in 2015.

PLWHA, when compared to the Utah population, are disproportionately racial and ethnic minorities. Males who are ethnic minorities account for 31% of males living with HIV.

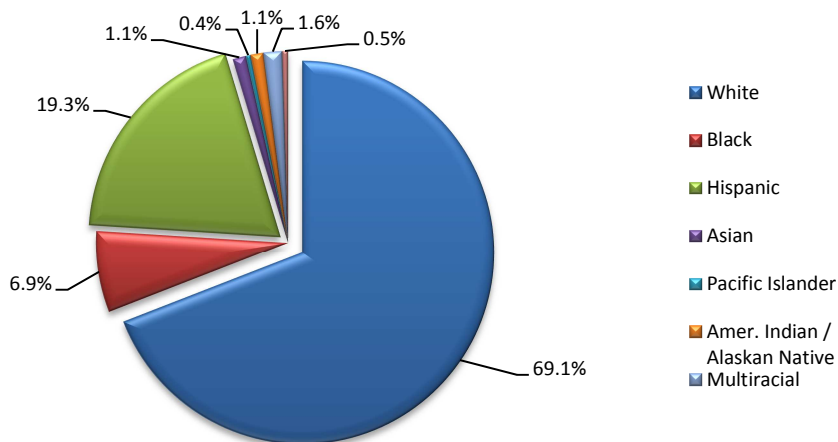
Likewise ethnic minority females who are living with HIV account for 51% of female infections.

The highest rates are found among Hispanics and non-Hispanic blacks. Again, only 14% of the Utah population is Hispanic; however, Hispanics account for 19% of men living with HIV and 20% of women living with HIV. Black, non-hispanics in Utah only make up 1% of the population but they account for 7% of male PLWHA and 24% of female PLWHA.

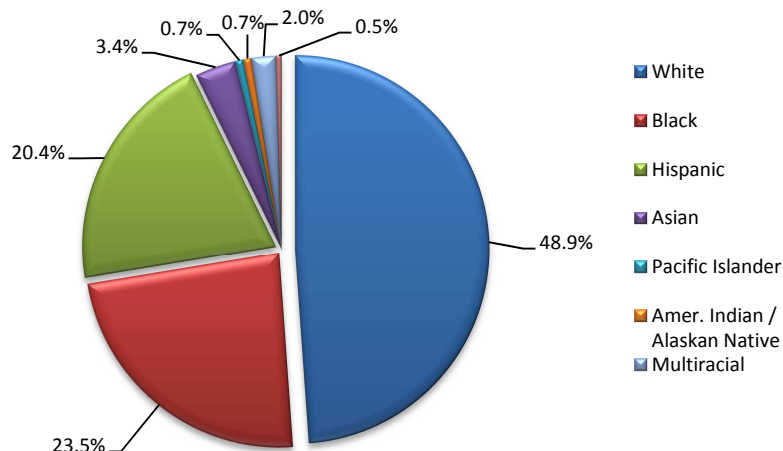
Utah Population Estimates by Race/Ethnicity— 2015



Males Living with HIV/AIDS by Race/Ethnicity— Utah, 2015



Females Living with HIV/AIDS by Race/Ethnicity— Utah, 2015



Understanding the racial and ethnic disparities of HIV infection is an important consideration for targeting services such as testing and access to preventive care. UDOH continues to gather more information about these disparities to further prevention efforts for minority populations throughout the state of Utah.

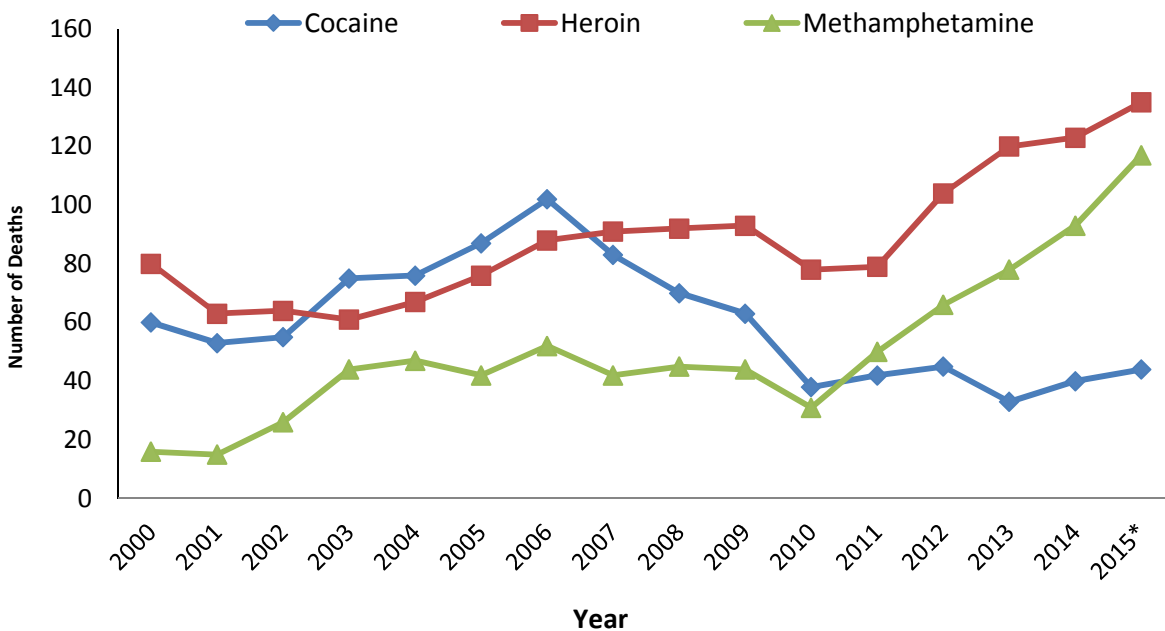
Risk Indicators for HIV Infection

Injection Drug Use

The recent drug overdose epidemic in the United States has brought attention and concerns regarding the transmission of blood-borne pathogens to national, state, and local health agencies' attention. Injection drug use, being a multifaceted issue, has required the collaboration between many state agencies as well as programs within UDOH. In recent years, surveillance efforts have increased around drug use and overdose deaths in Utah and have improved the ability to understand the epidemic at our local level.

Beginning in 2010, the number of illicit drug overdose deaths dramatically increased for heroin and methamphetamine use. There were only 31 deaths in Utah in 2010 attributed to methamphetamine overdose. This increased to 117 in 2015, a 277% increase. This increase in deaths from drug overdose is considered an indicator for increased risk of disease transmission for HIV and other diseases such as hepatitis C, as drugs such as methamphetamine and heroin are often injected.

Number of Unintentional and Undetermined Illicit Drug Overdose Deaths— Utah 2000-2015



*2015 data is preliminary. Data Source: Utah Violent Death Reporting System

Utah has started making significant efforts toward reducing the risk of disease transmission among injection drug users. Syringe exchanges programs became legal in Utah on March 25, 2016, after the House Bill 308 was approved by the Utah House of Representatives, the Utah Senate, and signed by the Governor of Utah. The bill states that agencies in Utah “may operate a syringe exchange program in the state to prevent the transmission of disease and reduce morbidity and mortality among individuals who inject drugs and those individuals’ contacts.” During this same time period, other bills were signed into law that benefit public health and safety efforts to combat the epidemic. One example is a bill that permits distribution of Naloxone, a life saving drug to be used when an individual has overdosed and is at risk of dying.

Just weeks after the syringe exchange bill became law, UDOH created the Utah Syringe Exchange Network. Immediately, the community, including local public health, medical providers, and community-based organizations, jumped on board to begin planning how Utah was going to implement and manage syringe exchanges.

HIV Testing in Utah

HIV testing continues to remain an important indicator for reducing the spread of the virus. HIV testing in Utah has historically been a challenge for public health. However, UDOH, LHDs, and many community-based organizations work together to ensure as many individuals in Utah, especially those at risk, are tested each year. One area that has proven difficult to improve is collaboration with providers to promote more universal testing for HIV. Unfortunately, neither providers nor patients in Utah prioritize HIV testing as routine medical care.

Data is very limited in determining how many people in Utah are getting HIV tests. The Behavioral Risk Factor Surveillance System (BRFSS) provides some insight toward the HIV testing efforts in Utah. During the surveys, the BRFSS includes the question, “*As far as you know, have you ever been tested for HIV? Do not count tests you may have had as part of a blood donation.*” Only adults answer this survey; therefore, the question assesses whether the adult has ever had an HIV test performed. The question has multiple limitations such as recall and social desirability bias. It also does not measure testing which the patient may not have realized was performed during a routine medical visit. However, the data collected does give some indication of HIV screening rates in Utah and knowledge of being tested. Unfortunately, the rates continue to be extremely low.

In 2015, only 24% of all respondents had ever been tested for HIV. The results did vary by county and some areas (with sufficient data) had higher rates. As an example, 36% of females in Sevier county were tested, which interestingly is one of the counties with the lowest prevalence of HIV. The lowest percentage was 14.5% of females in Box Elder County. The relationship between male and female screening rates varies by county. In Salt Lake County, the county with the highest prevalence of HIV disease, males reported slightly lower rates of screening but rates were less than 30% for both males and females. Efforts in HIV testing, especially in areas where rates are high, must continue to increase.

**Percentage of Adults Ever Tested for HIV by
County and Sex - Utah, 2015**

	Male	Female
Beaver	**	**
Box Elder	15.0	16.9
Cache	17.4	20.4
Carbon	32.6*	32.1
Daggett	**	**
Davis	27	18.7
Duchesne	17.9*	20.0*
Emery	**	46.5*
Garfield	**	**
Grand	22.8*	39.5*
Iron	27.9	20.8
Juab	**	31.7*
Kane	**	**
Millard	**	**
Morgan	**	**
Piute	**	**
Rich	**	**
Salt Lake	27.1	29.8
San Juan	**	26.4*
Sanpete	19.7*	12.5*
Sevier	15.6*	30.5
Summit	27.8	24.9
Tooele	26.3	25.8
Uintah	31.8	34.4
Utah	17.7	17.9
Wasatch	17.2*	35.6
Washington	18.7	23.7
Wayne	47.8*	**
Weber	24.8	30.2

*Use caution in interpreting, The estimate has a coefficient of variation > 30% and is therefore deemed unreliable by Utah Department of Health standards.

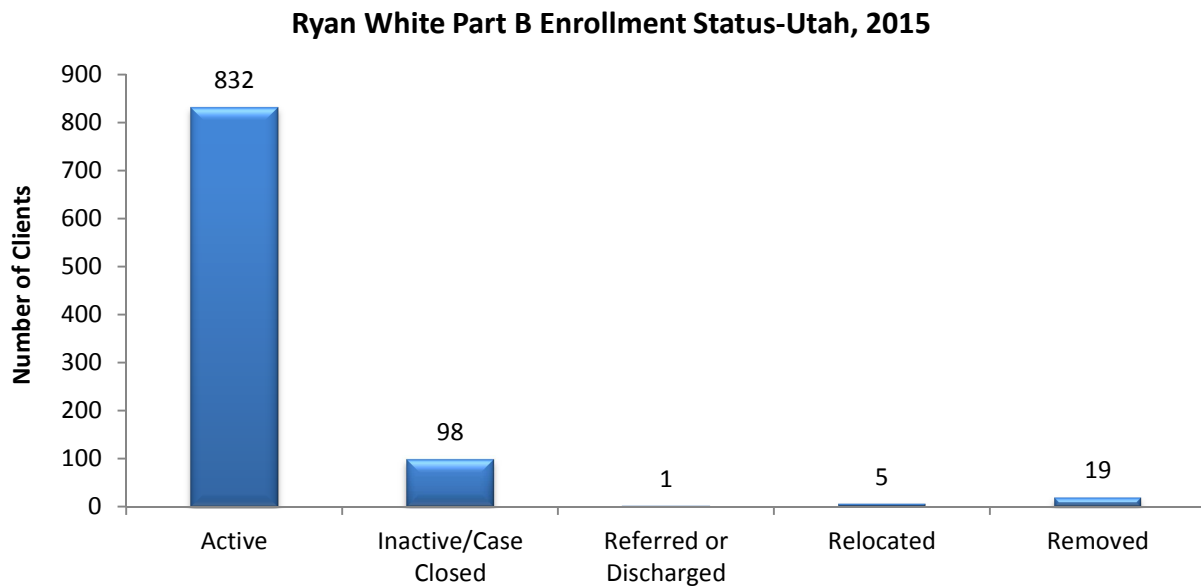
**The estimate has been suppressed because 1) the relative standard error is greater than 50% or when the relative standard error can't be determined. 2) the observed number of events is very small and not appropriate for publication, or 3) it could be used to calculate the number in a cell that has been suppressed.

Source: Utah Behavioral Risk Factor Surveillance System (BRFSS)

Ryan White Part B Program

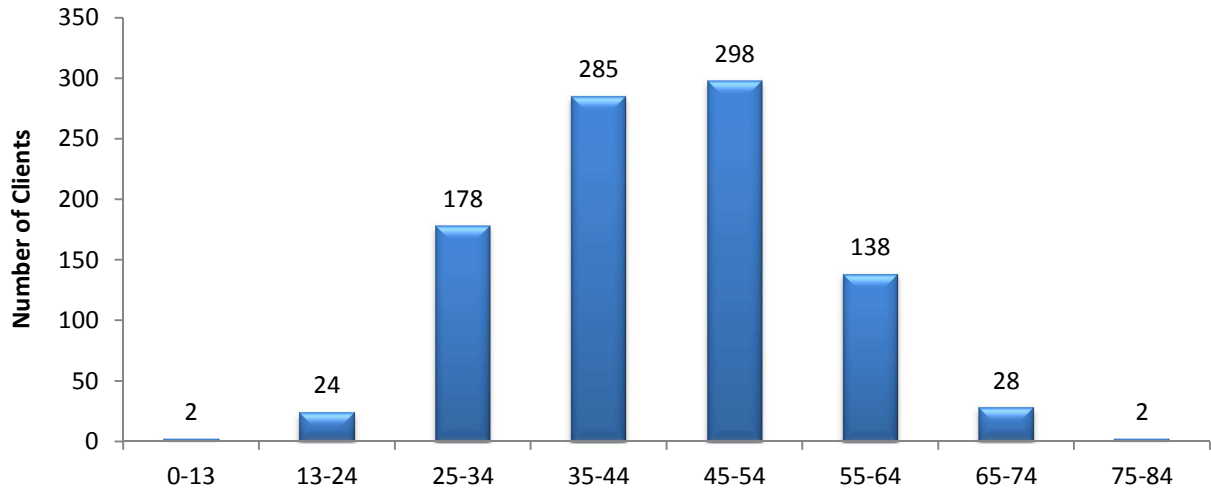
The Ryan White Part B Program at UDOH provides HIV services to PLWHA throughout the state of Utah. Clients are typically low income and qualify for additional assistance to ensure they have access to medications, ambulatory/outpatient care, and supportive services.

In 2015, the Ryan White Part B program had 832 active enrollees. The program provides services for roughly 28% of PLWHA in Utah. Of those who were determined to be in care during 2015, the Ryan White Part B Program provides services to roughly 36%.

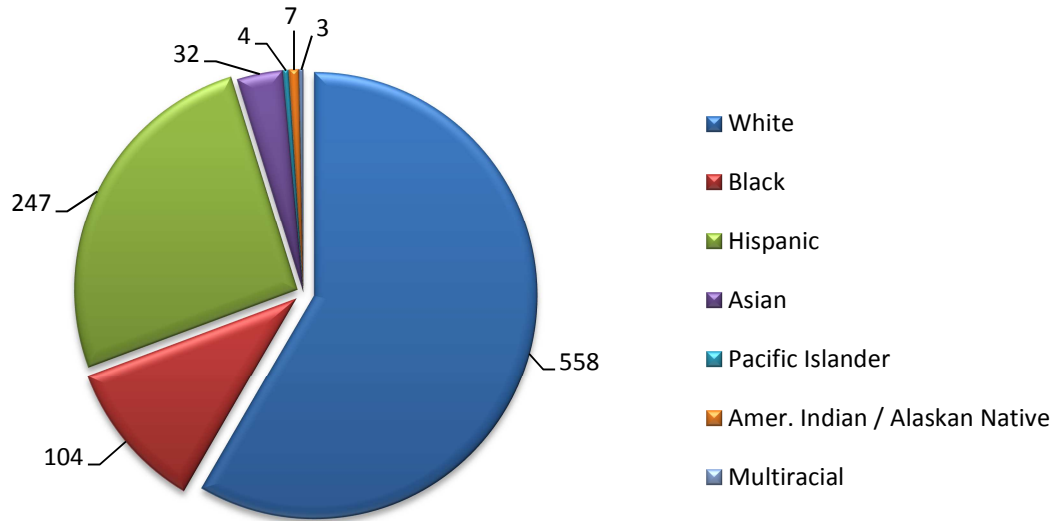


Ryan White clients were demographically very similar to the entire population of PLWHA in Utah in 2015. Clients range from children to the elderly. The majority of the clients however are middle aged, ranging from 35-54 years old. The majority of clients are White, non-Hispanic followed by Hispanic and Black. These trends are very similar to the demographics seen among all PLWHA in Utah during 2015.

Age Distribution of Ryan White Clients—Utah, 2015



Race/Ethnicity of Ryan White Clients—Utah, 2015



HIV Continuum of Care in Utah

The HIV Continuum of Care is a new model that is being implemented across the nation and in Utah to identify issues and opportunities related to improving the delivery of services to PLWHA. The HIV Continuum of Care has five main stages including: HIV diagnosis, linkage to care, retention in care, antiretroviral use, and viral suppression.

The HIV Continuum of Care provides a framework that depicts the series of stages a person with HIV engages in from initial diagnosis through successful treatment with HIV medication. It shows the proportion of individuals living with HIV who are engaged at each stage. The HIV Continuum of Care allows public health and key community stakeholders to measure progress and to direct HIV resources most effectively.

UDOH is closely monitoring linkage to care as defined by newly diagnosed individuals having a CD4 (T-lymphocyte cell), viral load (VL), or HIV genotype sequence performed after the date of diagnosis. When one of these laboratory results is reported to the health department, this indicates that the infected individual has been linked to a medical provider and their health is now being monitored. Linkage to care time frames are reviewed to determine how long a newly diagnosed individual is able to access care. The time frames are assessed at 1, 3, and 12 months.

The HIV Continuum of Care in Utah currently assesses a slightly different continuum. The stages of the continuum are HIV diagnosis, ever in care, currently in care, linked to care, retained to care. At this point, obtaining antiretroviral use data has proven difficult to collect. There is not enough data to accurately describe the antiretroviral (ARV) use of diagnosed individuals and therefore has been excluded from the report. Obtaining these data is a priority so UDOH is able to report on the complete continuum and understand how well PLWHA in Utah are taking medications to suppress their viral loads. Utah currently assesses the “In-Care” status of PLWHA in Utah by determining whether a patient has ever had a laboratory test performed to assess their care status. If the patient has had a laboratory test performed in the assessment time period, this indicates that the patient is “Currently in Care” and receiving services.

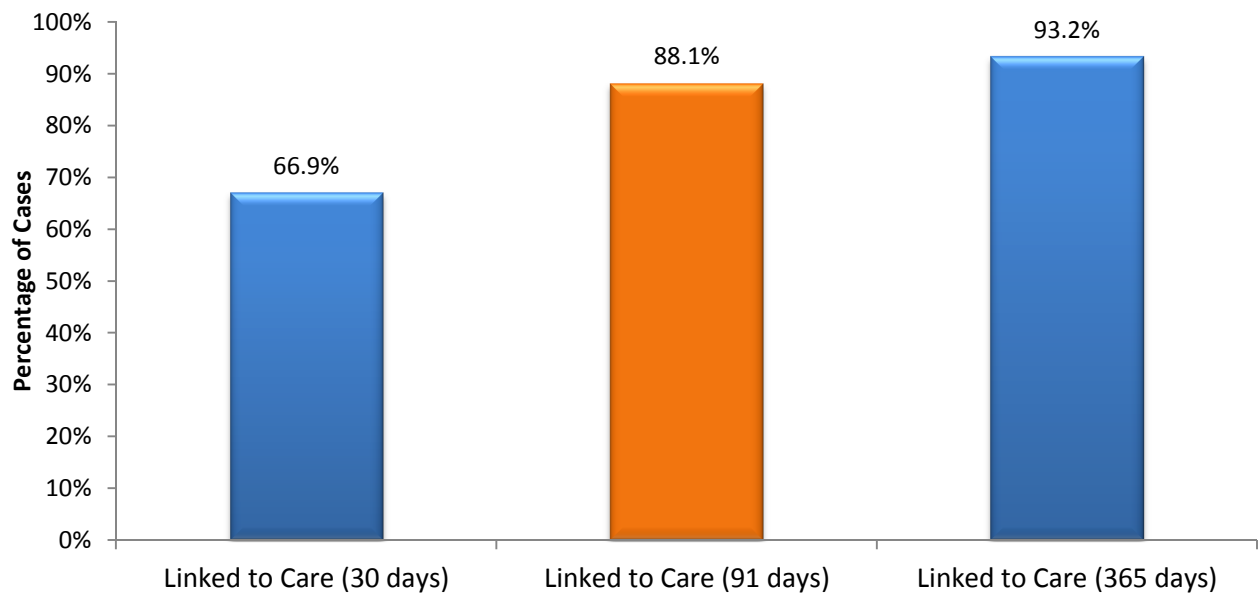
One of the most important aspects to the Continuum of Care is the assessment of viral suppression. The ultimate goal of ensuring PLWHA are in care and receiving ARV medication is to reduce the viral load, improving the patient’s health and reducing further spread of the HIV virus. Viral suppression is only assessed for those PLWHA who have received a viral load test result in the assessment time frame, meaning that they are currently in care. Increasing the viral suppression of those who have been diagnosed reduces the community viral load and prevents further infections.

Linkage to Care

Limiting the time it takes to link an individual newly diagnosed with HIV to HIV treatment and care is essential to ensuring that individual achieves viral suppression. Most newly diagnosed individuals with HIV are asymptomatic or are not experiencing symptoms. Without proper education on the disease, how it is transmitted, and how it will affect the person's life if viral suppression is not achieved, an infected individual is less likely to receive care increasing the likelihood of continued transmission.

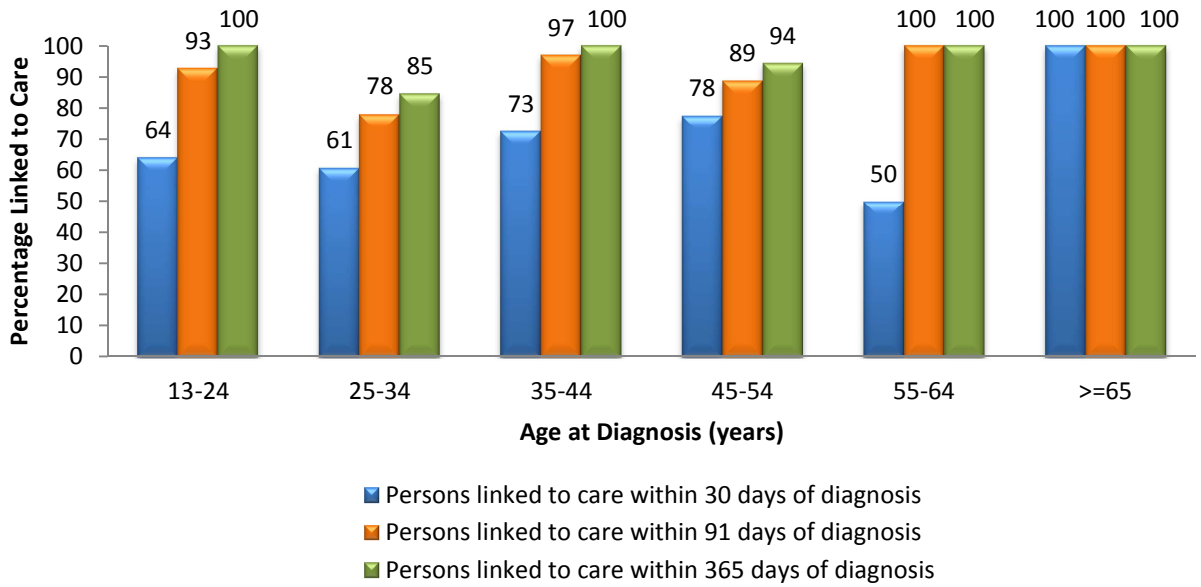
In 2015, Utah's linkage to care efforts were largely successful but still require improvement. Of newly diagnosed persons with HIV, 66.9% were linked to care within 30 days after their diagnosis. By 91 days, 88.1% were linked to care. The current standard for appropriate care linkage is 3 months. According to these data, Utah is doing very well. Unfortunately, only 93.2% of all the newly diagnosed persons with HIV were eventually linked to care within 365 days. Further investigation as to why it was unsuccessful to link persons to care will be a future priority for public health in Utah.

**Percentage of Newly Diagnosed HIV/AIDS Cases Linked to Care—
Utah, 2015**



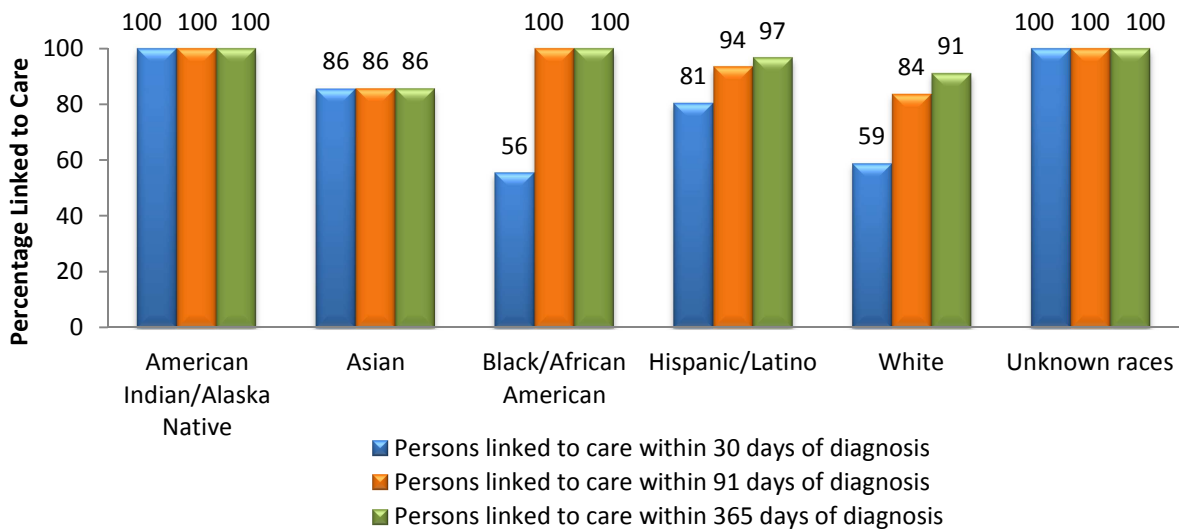
Further assessment of these linkage to care data has revealed some interesting observations that may lead to increasing future linkage to care rates. Reviewing the linkage to care data by age group shows that younger newly diagnosed individuals are less likely to be linked to care. The 25-34 year old age group had the lowest rate of linkage to care within 3 months (78.3%) and at one year (84.8%). Lower linkage to care rates may be due to this age group containing the largest proportion of newly diagnosed persons, resulting in more individuals to link to care. Another reason that may contribute to the lower linkage rate is that insurance for this age group may be more difficult to obtain or not a priority. Further data collection and evaluation will be required to assist in understanding these reasons. Only one other age group did not achieve 100% linkage to care within a year, the 45-54 year olds (94.4%).

Percentage of Newly Diagnosed HIV/AIDS Cases Linked to Care by Age Group—Utah, 2015

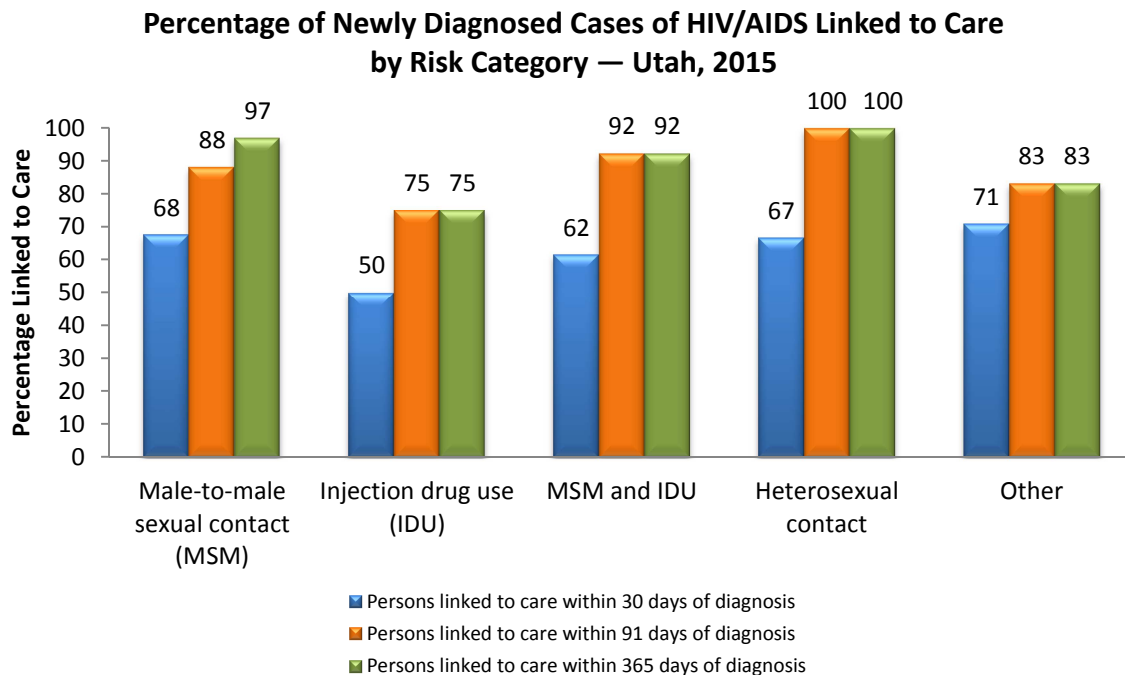


Racial and ethnic disparities have been noted with regard to the rates of new HIV diagnoses in Utah. However, with linkage to care, no clear distinctions have been found. White non-Hispanics had the lowest rate of linkage to care within 3 months compared to all other race or ethnic group. All minority racial groups other than Asians had better rates of linkage to care within a year than Whites. Again, newly diagnosed individuals in Utah are primarily White, resulting in more persons to link, which may explain this trend.

Percentage of Newly Diagnosed HIV/AIDS Cases Linked to Care by Race/Ethnicity— Utah, 2015



Reviewing linkage to care by risk category assists in understanding which individuals may be at higher risk of not entering HIV care. In 2015, those who identified injection drug use as their primary risk for becoming infected with HIV, were least likely to be linked to care within 3 months. Only 75% of the IDU risk category were linked to care within 3 months, suggesting further emphasis on linking those identifying an IDU risk to care is needed.



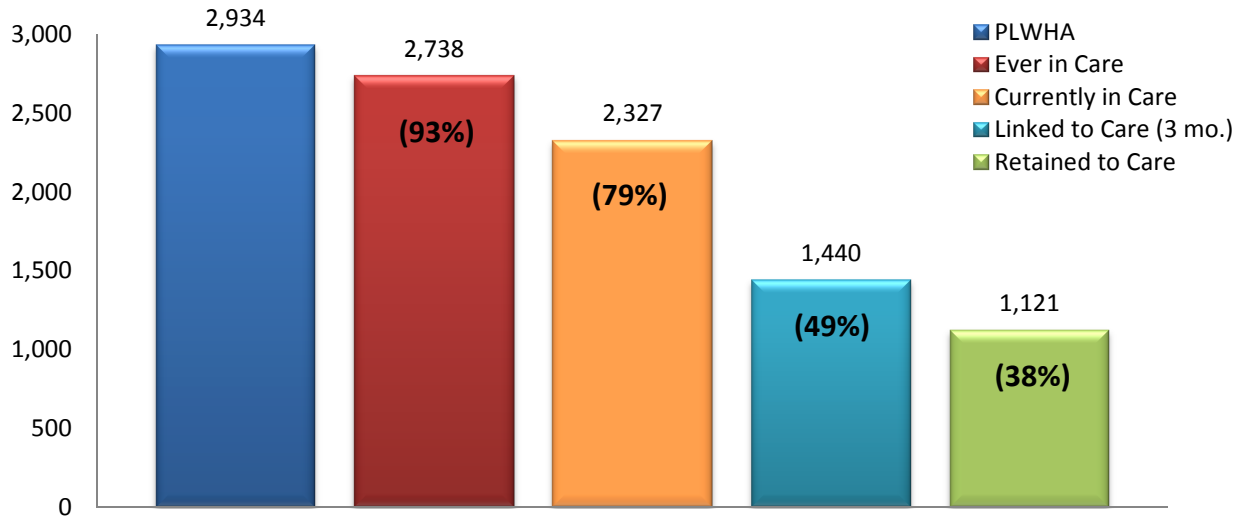
Continuum of Care

In 2015, the HIV Continuum of Care revealed some successes and some challenges facing HIV prevention and care efforts in the state of Utah. Of the PLWHA in Utah at the end of 2015, only 7% have never entered care and 79% were considered to be currently receiving or in care. While this still means that there are over 600 persons diagnosed with HIV in Utah who are not considered to be in care, these figures are much lower than originally expected.

Of the PLWHA, only 49% were linked to care within 3 months of their diagnosis. This figure may be lower than expected due to limited linkage to care efforts in previous years. Retention to care is another measure that shows how many PLWHA have HIV laboratory testing done to monitor their health in a year. Only 38% of those living with HIV had more than one medical visit in 2015. This may be an indication of retention to HIV care or simply how often medical providers are running HIV tests. Further analysis of this measure will be required to fully understand how patients are being monitored.

New efforts being implemented by UDOH will focus on those who are not in care and how to re-engage them into care. Linkage to care and HIV prevention specialists, epidemiologists, and local health officials are working toward the goal of 100% of the PLWHA being engaged in HIV care.

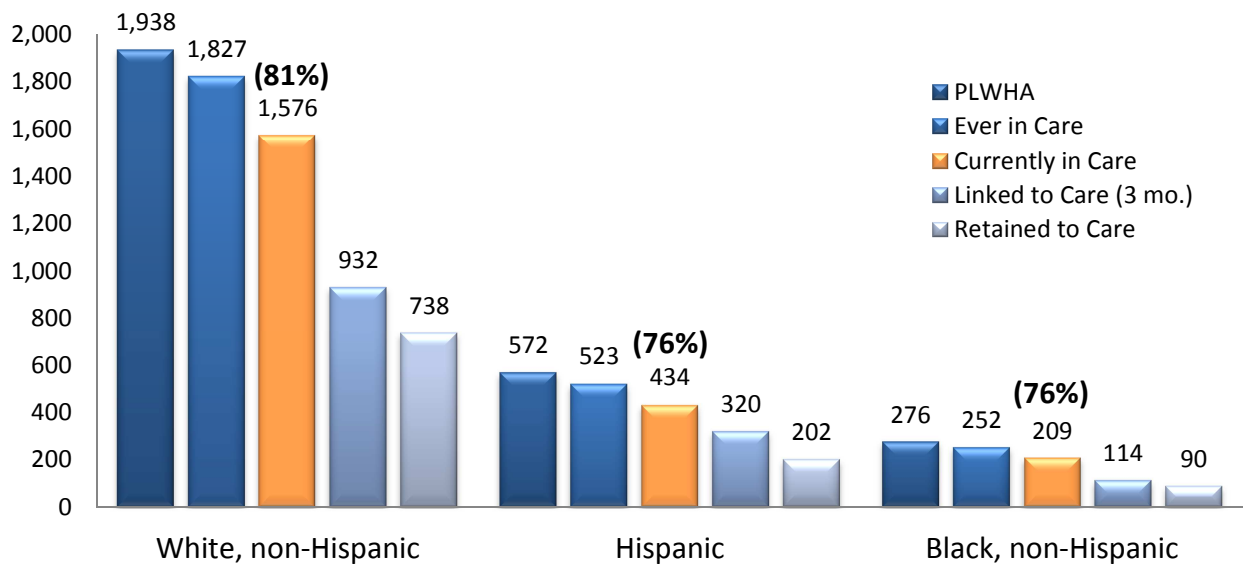
HIV Continuum of Care, Utah, 2015



One important way to improve the linkage and retention to HIV care is to look at specific populations to understand which groups may need a more focused approach to ensure they're receiving HIV treatment.

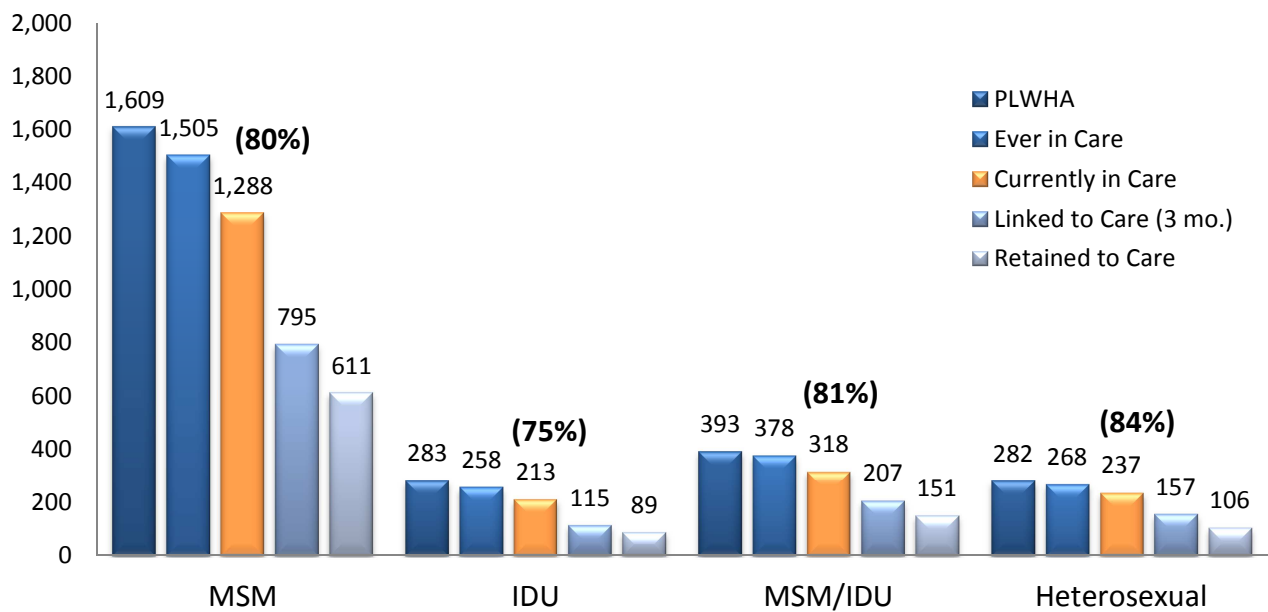
In 2015, PLWHA who were considered to be receiving care were slightly different as far as race and ethnicity. White non-Hispanics were more likely to be in care (81%) than Hispanics or Blacks (76%). While it is not clear what barriers may exist for being in HIV care, it is clear that different racial and ethnic groups should be considered a priority to ensure linkage to care is available and accessible.

HIV Continuum of Care by Race/Ethnicity, Utah, 2015



It is important to further understand what groups or populations may be experiencing difficulty accessing HIV medical care, especially among those identifying certain risk factors. PLWHA who have identified as MSM, MSM/IDU, or Heterosexual are all more likely to be in care than those only identifying IDU as their main risk. Only 75% of those who identified as IDU were currently in care in 2015. The other risk groups were above 80%, with heterosexual contact being the highest at 84%. More information is needed to fully understand the barriers around this particular group's access to care. Those who inject drugs are a population surrounded by many obstacles. It should be a priority to ensure that they have access to the medications and treatment required to be healthy and reduce further transmission of HIV.

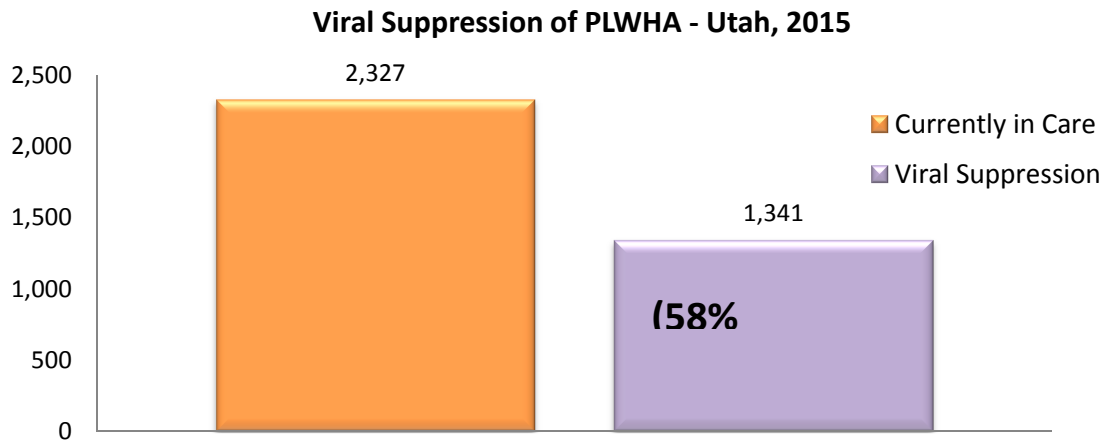
HIV Continuum of Care by Risk Category, Utah, 2015



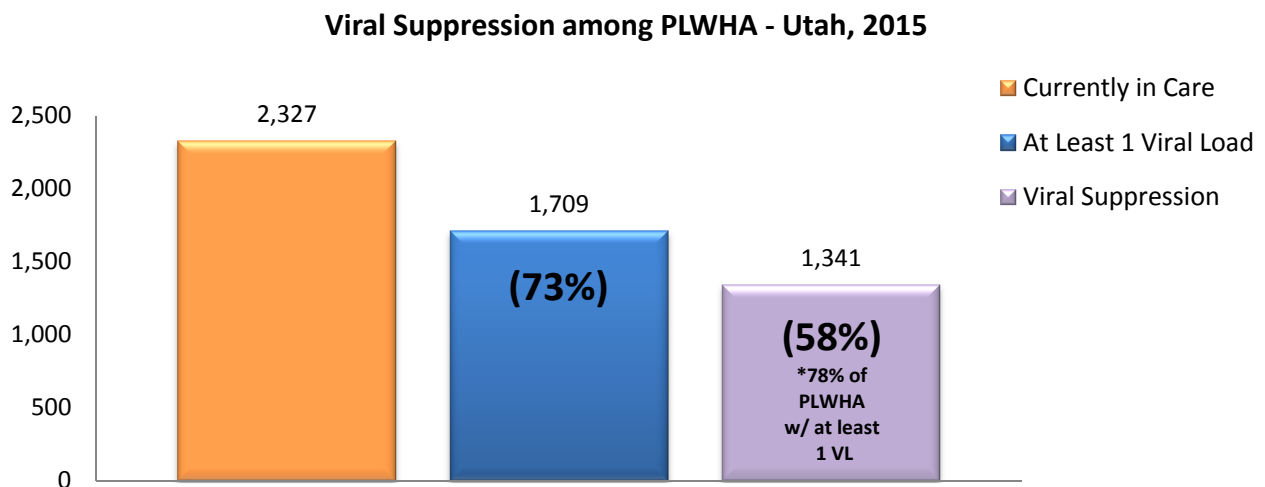
Viral Suppression

Over the last few years, recent research and publications have shown that reducing the viral load of a person infected with HIV will greatly reduce the chances of transmission to another person. The current efforts focused on linkage and retention to HIV medical care all continue to focus on a primary outcome, viral suppression. In 2015, almost 80% of PLWHA in Utah were in care. However, of those who were in care, only 58% were virally suppressed.

While 58% was surprisingly low, 27% of those who were in care did not have a viral load result reported to public health. When analyzing only those persons for whom a test result was reported, 78% were found to have achieved viral suppression.



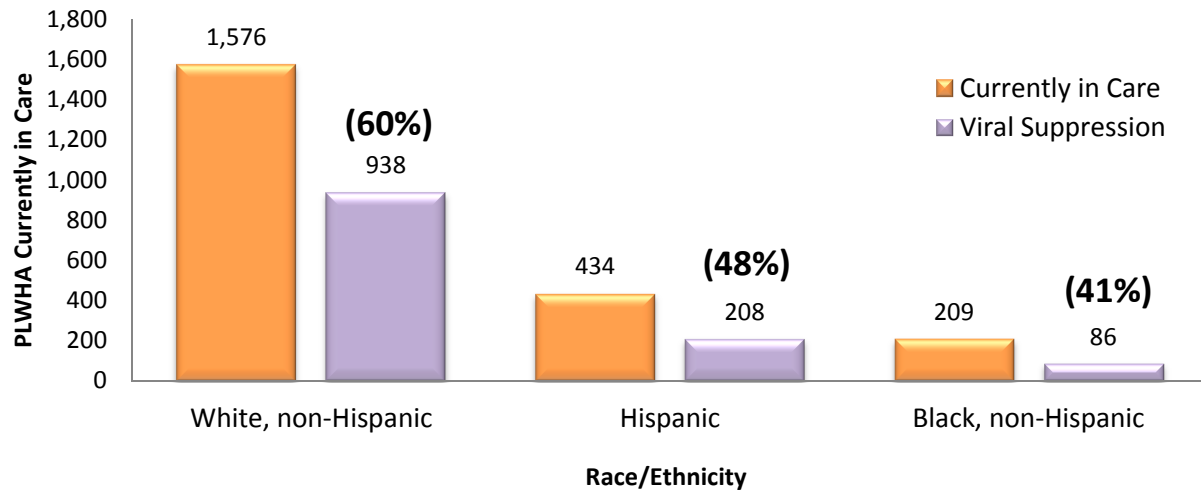
This analysis yielded two very important conclusions. First, UDOH has to determine whether laboratory results are not being reported to public health or if medical providers are not routinely performing viral load testing on their patients when they are seen at an office visit. Further understanding of routine laboratory testing may improve the viral suppression outcomes. Second, even among those with a reported viral load result, 22% still had not achieved viral suppression. More information needs to be gathered to determine why these patients who are currently in some form of HIV care had not achieved viral suppression.



In the continued effort to understand how specific populations receive HIV care, viral suppression was assessed by racial and ethnic group as well as risk category.

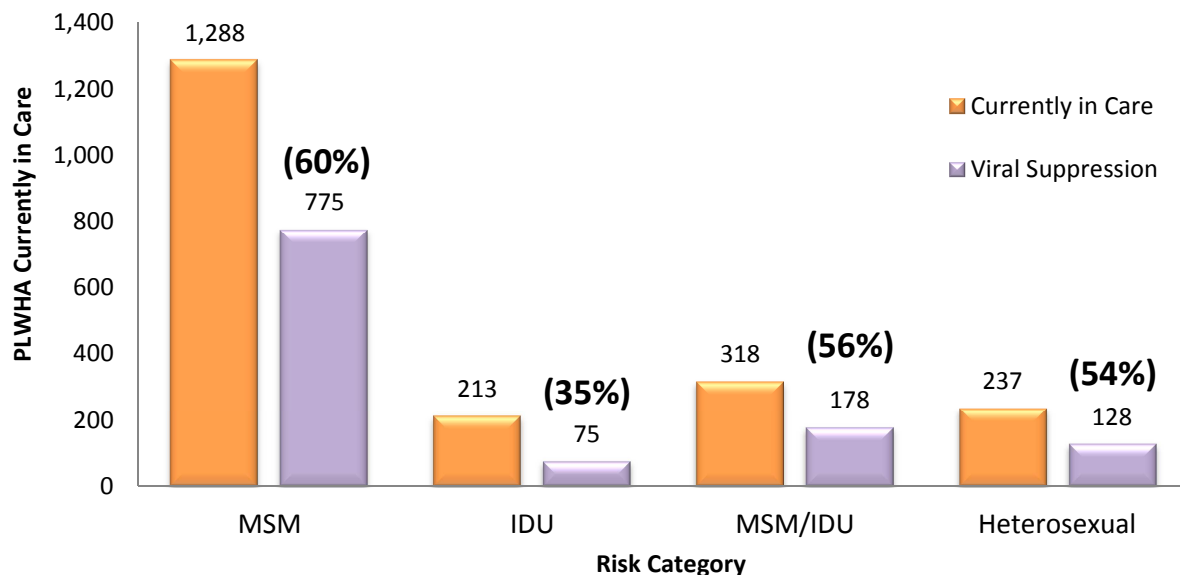
Unlike the results from the “In-Care” assessment, significant differences in viral suppression were observed by race and ethnicity. Of the White non-Hispanic PLWHA who were in care in 2015, 60% had achieved viral suppression. Rates of viral suppression among Hispanics and Blacks were much lower at 48% and 41% respectively. Further assessment is necessary in order to understand this health disparity.

Viral Suppression of PLWHA who are Currently In-Care by Race/Ethnicity - Utah, 2015



Of the four main risk groups, those PLWHA currently in care who identified as IDU were significantly less likely to achieve viral suppression compared with the other risk groups; only 35% had achieved viral suppression compared with 60% among MSM. MSM/IDU and heterosexual contact risk categories achieved better viral suppression rates at 56% and 54% respectively.

Viral Suppression of PLWHA who are Currently In-Care by Risk Category - Utah, 2015



Viral suppression is the primary measurement of the care continuum and the primary goal of HIV treatment efforts. Efforts to improve the data quality and reporting of this information is critical to further the understanding of the population of PLWHA in Utah and their care status. UDOH, in conjunction with local health departments, community-based organizations, and the medical community, will have to collaborate further to improve the health outcomes of those living with HIV.

Appendix A

Data Tables

Characteristics of Individuals Reported as Newly Diagnosed with HIV, Utah, 2015

	Females		Males		Total	
	Number	Percent	Number	Percent	Number	Percent
Transmission Category						
MSM	N/A	N/A	63	58%	63	53%
IDU	2	17%	3	3%	5	4%
MSM/IDU	N/A	N/A	12	11%	12	10%
Heterosexual	8	67%	15	14%	23	19%
NIR	2	17%	15	14%	17	14%
Age Group						
<15	0	—	0	—	0	—
15-24	1	8%	13	12%	14	12%
25-34	3	25%	44	41%	47	39%
35-44	4	33%	29	27%	33	28%
45-54	3	25%	15	14%	18	15%
55-64	1	8%	6	6%	7	6%
65+	0	—	1	1%	1	1%
Race/Ethnicity						
American Indian/Alaska Native	0	—	2	2%	2	2%
Asian, non-Hispanic	1	8%	6	6%	7	6%
Black, non-Hispanic	4	33%	5	5%	9	8%
White, non-Hispanic	7	58%	62	57%	69	58%
Hispanic	0	0%	31	29%	31	26%
Foreign born						
Yes	5	42%	28	26%	33	28%
No	3	25%	54	50%	57	48%
Unknown	4	33%	26	24%	30	25%
Jurisdiction of Residence						
Bear River HD	0	—	2	2%	2	2%
Central Utah Public HD	0	—	1	1%	1	1%
Davis County HD	1	8%	10	9%	11	9%
Salt Lake County HD	9	75%	66	61%	75	63%
San Juan County HD	0	—	0	0%	0	—
Southeastern Utah District HD	0	—	3	3%	3	3%
Southwest Utah Public HD	0	—	9	8%	9	8%
Summit County HD	0	—	1	1%	1	1%
Tooele County HD	0	—	1	1%	1	1%
TriCounty HD	0	—	1	1%	1	1%
Utah County HD	1	8%	11	10%	12	10%
Wasatch County HD	0	—	0	0%	0	—
Weber-Morgan HD	1	8%	3	3%	4	3%
AIDS at Diagnosis						
No	10	83%	85	79%	95	79%
Yes	2	17%	23	21%	25	21%
Total Cases						
	12	10%	108	90%	120	100%

Table 1. Counts and Rates of New HIV Diagnoses by County, Utah, 2006-2015

	2006		2007		2008		2009		2010		2011		2012		2013		2014		2015	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
Beaver	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Box Elder	1	2.2	1	2.1	1	2.1	1	2.0	2	4.0	—	—	3	6.0	—	—	—	—	1	1.9
Cache	—	—	1	1.0	—	—	4	3.6	2	1.8	2	1.7	1	0.9	3	2.6	1	0.8	1	0.8
Carbon	—	—	—	—	—	—	1	4.7	—	—	—	—	—	—	1	4.8	—	—	2	9.8
Daggett	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Davis	7	2.5	7	2.4	9	3.0	13	4.3	11	3.6	2	0.6	11	3.5	6	1.9	8	2.4	11	3.3
Duchesne	—	—	—	—	—	—	—	—	—	—	1	5.3	1	5.2	—	—	—	—	1	4.8
Emery	1	9.6	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Garfield	—	—	—	—	—	—	—	—	1	19.3	—	—	—	—	—	—	—	—	—	—
Grand	—	—	2	22.6	—	—	—	—	—	—	—	—	—	—	—	—	1	10.6	1	10.5
Iron	—	—	—	—	1	2.2	—	—	—	—	—	—	—	—	1	2.1	2	4.2	1	2.1
Juab	—	—	—	—	—	—	—	—	—	—	—	—	1	9.7	—	—	—	—	—	—
Kane	—	—	—	—	—	—	1	14.3	—	—	—	—	—	—	—	—	—	—	—	—
Millard	—	—	—	—	—	—	—	—	1	8.0	—	—	—	—	—	—	1	8.0	—	0.0
Morgan	—	—	—	—	1	11.0	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Piute	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Rich	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Salt Lake	101	10.4	89	9.0	94	9.4	92	9.0	57	5.5	84	8.0	66	6.2	75	6.9	88	8.1	75	6.8
San Juan	—	—	—	—	1	6.9	—	—	—	—	—	—	1	6.7	1	6.7	—	—	—	—
Sanpete	—	—	—	—	1	3.7	—	—	—	—	—	—	—	—	—	—	—	—	1	3.5
Sevier	—	—	—	—	—	—	—	—	—	—	1	4.8	—	—	—	—	—	—	—	—
Summit	2	5.8	—	—	1	2.8	—	—	1	2.7	2	5.3	—	—	1	2.6	1	2.6	1	2.5
Tooele	—	—	1	1.9	2	3.6	2	3.5	2	3.4	4	6.7	3	5.0	1	1.6	2	3.2	1	1.6
Uintah	—	—	1	3.3	—	—	1	3.0	—	—	—	—	1	2.9	3	8.4	—	—	—	—
Utah Co	3	0.7	3	0.6	8	1.6	6	1.2	8	1.5	2	0.4	17	3.1	6	1.1	5	0.9	12	2.1
Wasatch	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Washington	5	3.9	3	2.3	1	0.7	2	1.5	2	1.4	3	2.1	7	4.8	1	0.7	4	2.6	8	5.1
Wayne	—	—	—	—	—	—	—	—	—	—	—	—	1	36.7	—	—	—	—	—	—
Weber	6	2.8	9	4.1	8	3.6	2	0.9	1	0.4	5	2.1	4	1.7	8	3.4	5	2.1	4	1.6
Unknown	—	—	—	—	2	—	2	—	—	—	—	—	1	—	1	—	—	—	—	—
State of Utah	126	5.0	117	4.5	130	4.9	127	4.7	88	3.2	106	3.8	118	4.1	108	3.7	118	4.0	120	4.0

Table 2a. Counts and Rates of New HIV Diagnoses for Males by Age Group Utah, 2006-2015

	2006		2007		2008		2009		2010		2011		2012		2013		2014		2015	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
<15	—	—	1	0.3	1	0.3	—	—	2	0.5	1	0.3	—	—	2	0.5	—	—	—	—
15-24	16	7.1	13	5.7	22	9.7	22	9.8	20	8.9	21	9.2	18	7.7	20	8.4	19	7.9	13	5.3
25-34	36	17.8	26	12.3	29	13.2	31	13.7	11	4.8	23	10.1	33	14.7	36	16.1	42	18.8	44	19.7
35-44	35	22.6	30	18.9	32	19.8	30	18.1	26	15.2	22	12.4	15	8.2	17	8.9	22	11.2	29	14.2
45-54	17	11.8	18	12.1	22	14.6	18	11.8	11	7.2	18	11.8	21	13.7	13	8.5	9	5.8	15	9.6
55-64	3	3.0	5	4.8	6	5.5	7	6.2	3	2.5	3	2.4	9	7.0	5	3.8	6	4.4	6	4.3
65+	—	—	1	1.0	1	0.9	2	1.8	1	0.9	1	0.8	—	—	1	0.8	2	1.5	1	0.7
Unknown	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Total	107	8.4	94	7.2	113	8.4	110	8.0	74	5.3	89	6.3	96	6.7	94	6.4	100	6.8	108	7.2

Table 2b. Counts and Rates of New HIV Diagnoses for Females by Age Group Utah, 2006-2015

	2006		2007		2008		2009		2010		2011		2012		2013		2014		2015	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
<15	—	—	—	—	—	—	1	0.3	1	0.3	1	0.3	—	—	1	0.3	2	0.5	—	—
15-24	3	1.4	6	2.7	3	1.4	2	0.9	2	0.9	3	1.3	2	0.9	2	0.9	2	0.9	1	0.4
25-34	6	3.1	6	3.0	6	2.9	6	2.8	3	1.4	6	2.7	6	2.8	3	1.4	5	2.3	3	1.4
35-44	7	4.7	7	4.6	4	2.6	6	3.8	6	3.7	2	1.2	10	5.7	5	2.7	6	3.2	4	2.0
45-54	2	1.4	2	1.3	2	1.3	2	1.3	1	0.6	2	1.3	2	1.3	2	1.3	2	1.3	3	1.9
55-64	1	1.0	2	1.9	2	1.8	—	—	1	0.8	3	2.3	1	0.8	1	0.7	1	0.7	1	0.7
65+	—	—	—	—	—	—	—	—	—	—	—	—	1	0.7	—	—	—	—	—	—
Unknown	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Total	19	1.5	23	1.8	17	1.3	17	1.3	14	1.0	17	1.2	22	1.5	14	1.0	18	1.2	12	0.8

Table 3a. Counts and Percentages of New HIV Diagnoses for Males by Transmission Category Utah, 2006-2015

	2006		2007		2008		2009		2010		2011		2012		2013		2014		2015	
	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt
MSM	68	64%	68	72%	73	65%	66	60%	51	69%	52	58%	54	56%	59	63%	60	60%	63	58%
IDU	8	7%	3	3%	3	3%	4	4%	2	3%	4	4%	1	1%	1	1%	2	2%	3	3%
MSM/IDU	19	18%	13	14%	20	18%	26	24%	17	23%	22	25%	17	18%	15	16%	12	12%	12	11%
Heterosexual	1	1%	2	2%	2	2%	3	3%	—	—	1	1%	5	5%	7	7%	13	13%	15	14%
NIR / Other	11	10%	8	9%	15	13%	11	10%	4	5%	10	11%	19	20%	12	13%	13	13%	15	14%
Total	107		94		113		110		74		89		96		94		100		108	

Table 3b. Counts and Percentages of New HIV Diagnoses for Females by Transmission Category Utah, 2006-2015

	2006		2007		2008		2009		2010		2011		2012		2013		2014		2015	
	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt
IDU	3	16%	6	26%	5	29%	2	12%	1	7%	2	12%	2	9%	3	21%	2	11%	2	17%
Heterosexual	5	26%	7	30%	8	47%	9	53%	5	36%	11	65%	8	36%	9	64%	13	72%	8	67%
NIR / Other	11	58%	10	43%	4	24%	6	35%	8	57%	4	24%	12	55%	2	14%	3	17%	2	17%
Total	19		23		17		17		14		17		22		14		18		12	

Table 4a. Counts and Percentages of New HIV Diagnoses for Males by Race/Ethnicity Utah, 2006-2015

	2006		2007		2008		2009		2010		2011		2012		2013		2014		2015	
	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt
Hispanic	31	29%	15	16%	19	17%	27	25%	20	27%	20	22%	23	24%	20	21%	28	28%	31	29%
American Indian/ Alaskan Native	—	—	3	3%	—	—	1	1%	—	—	—	—	4	4%	—	—	—	—	2	2%
Asian, non-Hispanic	1	1%	2	2%	1	1%	4	4%	—	—	4	4%	1	1%	2	2%	6	6%	6	6%
Black, non-Hispanic	7	7%	6	6%	6	5%	4	4%	5	7%	2	2%	3	3%	7	7%	8	8%	5	5%
Native Hawaiian/ Pacific Islander	—	—	—	—	1	1%	—	—	—	—	1	1%	—	—	—	—	—	—	—	—
White, non-Hispanic	68	64%	67	71%	86	76%	70	64%	47	64%	58	65%	62	65%	61	65%	56	56%	62	57%
Multiracial	—	—	1	1%	—	—	4	4%	2	3%	3	3%	2	2%	4	4%	—	—	—	—
Unknown	—	—	—	—	—	—	—	—	—	—	1	1%	1	1%	—	—	2	2%	2	2%
Total	107		94		113		110		74		89		96		94		100		108	

Table 4b. Counts and Percentages of New HIV Diagnoses for Females by Race/Ethnicity Utah, 2006-2015

	2006		2007		2008		2009		2010		2011		2012		2013		2014		2015	
	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt	Count	Pcnt
Hispanic	2	11%	4	17%	3	18%	3	18%	7	50%	5	29%	2	9%	1	7%	2	11%	—	—
American Indian/ Alaskan Native	—	—	—	—	—	—	—	—	—	—	—	—	1	5%	—	—	—	—	—	—
Asian, non-Hispanic	1	5%	—	—	1	6%	2	12%	1	7%	2	12%	1	5%	1	7%	2	11%	1	8%
Black, non-Hispanic	8	42%	6	26%	4	24%	8	47%	3	21%	3	18%	4	18%	6	43%	3	17%	4	33%
Native Hawaiian/ Pacific Islander	1	5%	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
White, non-Hispanic	7	37%	13	57%	9	53%	4	24%	3	21%	7	41%	12	55%	5	36%	9	50%	7	58%
Multiracial	—	—	—	—	—	—	—	—	—	—	—	—	2	9%	1	7%	—	—	—	—
Unknown	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—
Total	19		23		17		17		14		17		22		14		18		12	