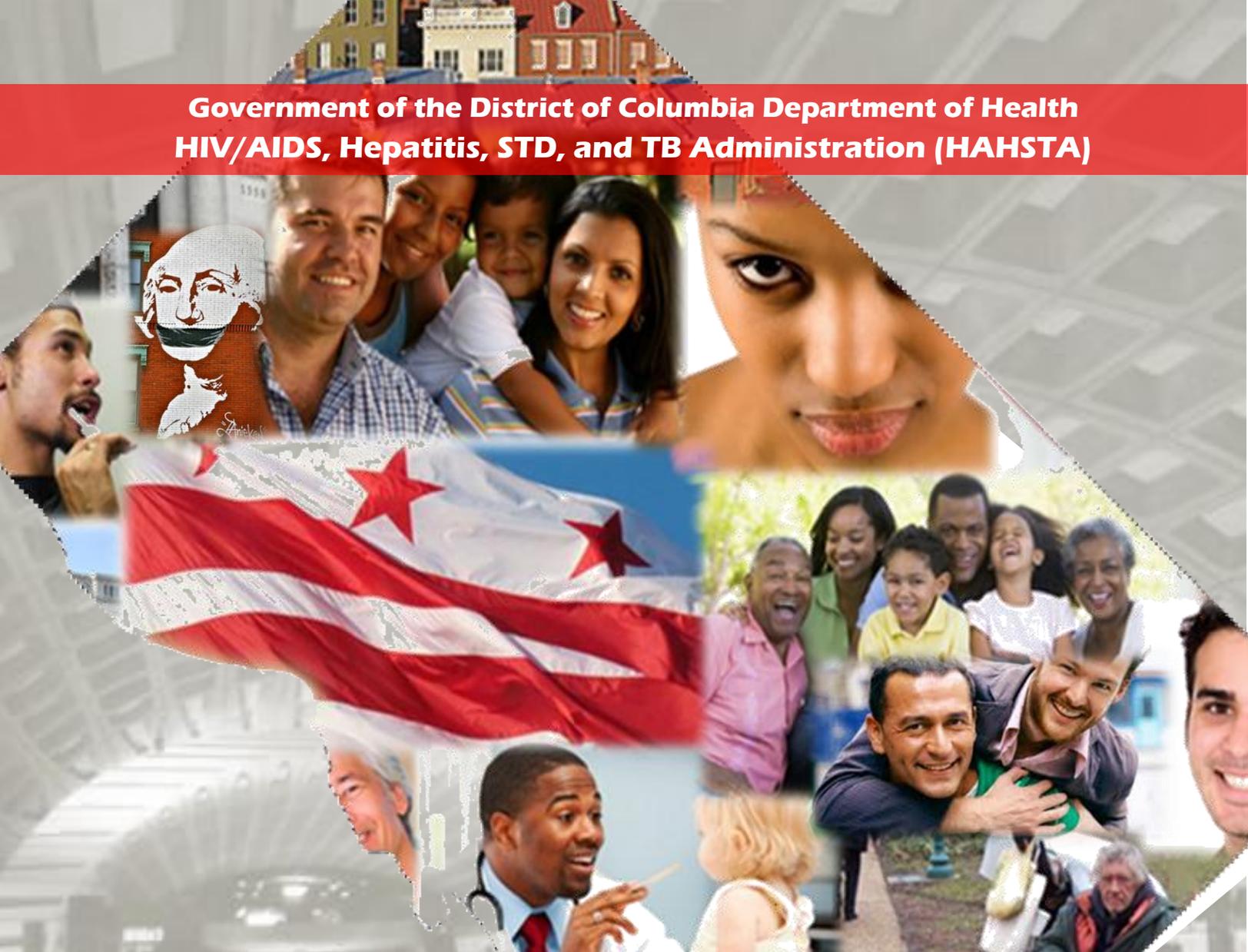


**Government of the District of Columbia Department of Health
HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA)**



HIV among Transgender Persons in the District of Columbia

HIV/AIDS, Hepatitis, STD, and TB Data through 2014



Muriel Bowser
Mayor, District of Columbia



GOVERNMENT OF THE DISTRICT OF COLUMBIA



HIV among Transgender Persons in the District of Columbia

Acknowledgments

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With special thanks to:

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HIV among Transgender Persons in the District of Columbia

HIV among Transgender Persons in the District of Columbia

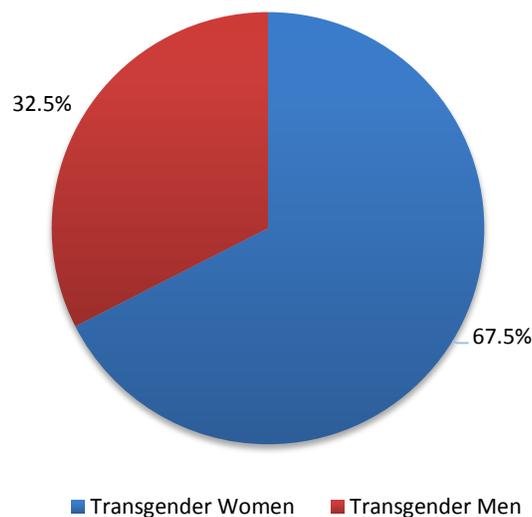
The DC Department of Health (DOH) reports the impact of HIV, Sexually Transmitted Diseases (STDs), viral hepatitis, and tuberculosis on the District of Columbia as a whole, by population groups and by ward. Having these statistics can help communities and health care providers best plan for programs that will help reduce new infections, connect people into care and treatment, and achieve better health outcomes for our residents. There continues to be progress diagnosing people earlier in their disease; getting people quicker into medical care and reducing the chances that their disease will get worse. DOH can report that the number of new HIV cases declined city-wide while there was a continued increase in the number of people entering medical treatment within 3 months.

This supplement provides a detailed analysis of demographic and HIV care data for transgender persons in the District of Columbia. Here are the key findings of this supplement on transgender persons living with HIV in the District:

- At the end of 2013, there were a total of 16,423 residents of the District of Columbia diagnosed and living with HIV, of which 246 (1.5%) were among transgender persons.
- Two-thirds of transgender persons living with HIV are transgender women.
- High rates of transgender persons were linked to care (96.3%), received care in 2014 (69.9%) and achieved viral suppression (62.2%), which are higher than the District's average.
- One-third of transgender persons were initially diagnosed with Stage 3 HIV disease, previously known as an AIDS diagnosis. Though some of those persons were able to increase their CD4 counts to Stage 1 or Stage 2, 54% remained at Stage 3. Overall, among HIV positive persons who were ever diagnosed at Stage 3, only 25% were documented to have Stage 3 disease based on the last CD4-related laboratory information received by the health department.

HIV Overview

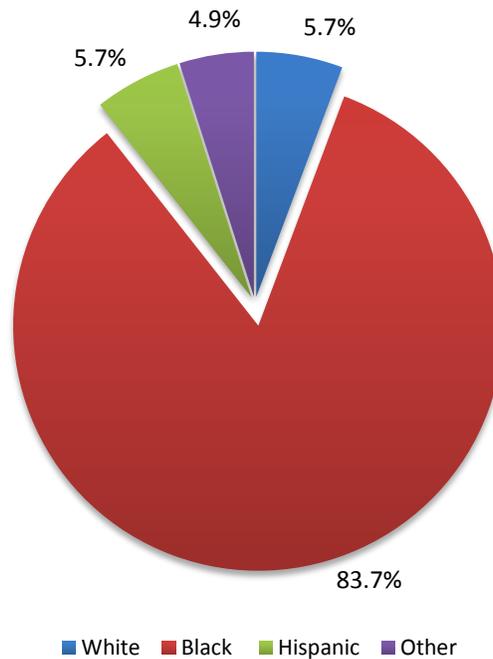
Figure 1. Transgender Persons Living with HIV by Gender Identity, 2013



HIV among Transgender Persons in the District of Columbia

- There were 16,423 residents of the District of Columbia living with HIV as of December 31, 2013. Of these cases 246 (1.5%) were transgender. The majority of transgender cases were transgender women (67.5%).

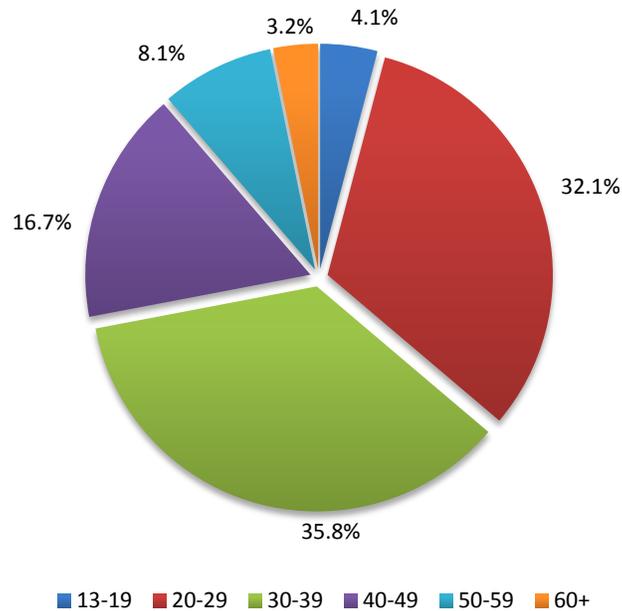
Figure 2. Transgender Persons Living with HIV by Race/Ethnicity, 2013



- Over three-quarters (84.1%) of transgender persons living with HIV in the District are black.

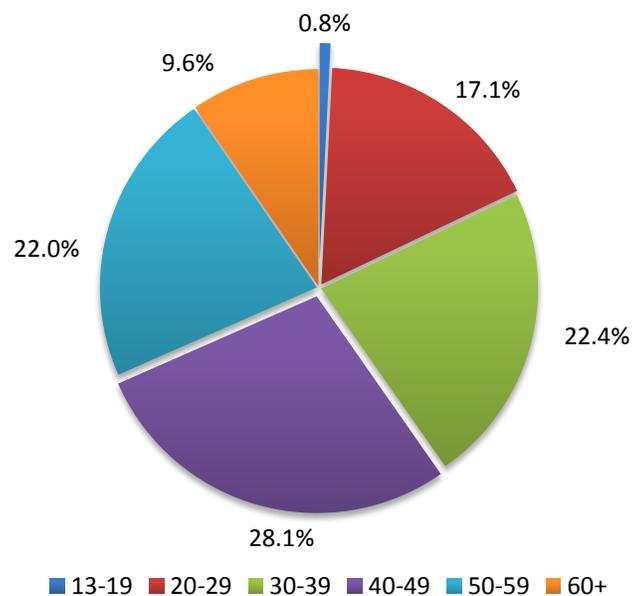
Figure 3. Transgender Persons Living with HIV by Age at Diagnosis, 2013

HIV among Transgender Persons in the District of Columbia



- Nearly a third (29.0%) of transgender persons living with HIV were diagnosed between the ages of 20-29 years of age, and one-third (33.5%) were diagnosed between 30 and 39 years of age (Figure 3).

Figure 4. Transgender Persons Living with HIV by Current Age, 2013



- As of December 31, 2013, over three-quarters (83.7%) of transgender persons living with HIV in the District were between the ages of 20 and 49.

HIV among Transgender Persons in the District of Columbia

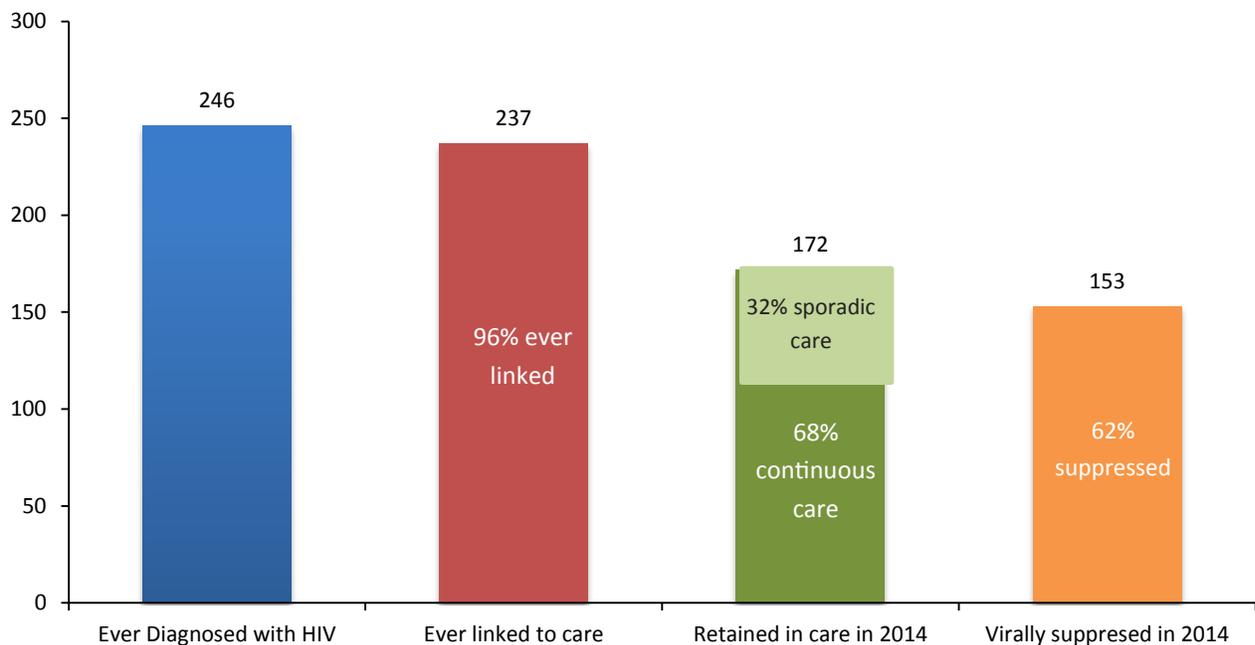
HIV Care Dynamics

The data contained in this section provide important insight into how the HIV care system is ensuring healthy outcomes for persons living with HIV. The Department of Health will continue its collaboration with providers and engage with the community in meaningful ways to address gaps and enhance the care system.

Table 1. Care Dynamics Measure Definitions

Measure	Definition	Levels
Reported HIV Diagnoses	Number of HIV cases among District residents reported to the DC Department of through 2013	-
Linkage to Care	Evidence of first CD4 and/or viral load** lab after diagnosis	
Care Status	Stability of care in 2014	Retained: At least two viral load and/or CD4 labs reported more than 60 days apart in 2014 Sporadic: One viral load or CD4 lab reported in 2014 Out of care: No lab reported in 2014
Ever Virally Suppressed	Suppression any time after HIV disease diagnosis	Suppressed: reported viral load ≤ 200 copies/mL Not suppressed: reported viral load > 200 copies/mL No viral load reported
Last Known Viral Status	Suppression status at last known viral load in 2014	Suppressed: reported viral load ≤ 200 copies/mL Not suppressed: reported viral load > 200 copies/mL No viral load reported in 2014

Figure 5. Care Dynamics among Transgender Persons, 2014



HIV among Transgender Persons in the District of Columbia

- Figure 5 represents the 2014 care continuum for transgender HIV cases who were living as of December 31, 2013. Among the 246 diagnosed living HIV transgender cases, 96.3% were ever linked to care, with 50% of cases being linked to care with 3 months of diagnosis. Nearly three-quarters (72.8%) received any care in 2014, of which 68.0% had received continuous care in 2014. Of all living transgender cases diagnosed, 62.2% achieved viral suppression at last lab in 2014.

HIV among Transgender Persons in the District of Columbia

Table 2. 2014 Care Dynamics among Diagnosed and Living Transgender HIV Cases by Selected Characteristics

	Living HIV Cases Diagnosed		Ever Linked to Care		Retained in Care		Retained in Continuous Care in 2014†		Ever Virally Suppressed		Suppressed at Last Known Viral Status in 2014†	
	N		N	%	N	%	N	%	N	%	N	%
Sex												
Transgender women	166		159	95.8	113	68.1	79	47.6	117	70.5	102	61.4
Transgender men	80		78	97.5	59	73.8	38	47.5	58	72.5	51	63.8
Race/Ethnicity												
White	14		14	100.0	9	64.3	3	21.4	13	92.9	9	64.3
Black	206		198	96.1	143	69.4	105	51.0	141	68.4	125	60.7
Hispanic	14		13	92.9	12	85.7	6	42.9	11	78.6	10	71.4
Other*	12		12	100.0	8	66.7	3	25.0	10	83.3	9	75.0
Mode of Transmission												
IDU	15		15	100.0	14	93.3	12	80.0	12	80.0	12	80.0
Sexual contact	167		161	96.4	114	68.3	75	45%	118	70.7	102	61.1
Sexual contact/IDU	16		16	100.0	11	68.8	8	50.0	13	81.3	11	68.8
RNI/Other**	48		45	93.8	33	68.8	22	45.8	32	66.7	28	58.3
Current Age												
0-19	2		2	100.0	2	100.0	1	50.0	1	50.0	1	50.0
20-29	42		41	97.6	25	59.5	15	35.7	23	54.8	22	52.4
30-39	55		51	92.7	41	74.5	27	49.1	37	67.3	32	58.2
40-49	69		67	97.1	46	66.7	32	46.4	51	73.9	41	59.4
50-59	54		53	98.1	41	75.9	31	57.4	42	77.8	40	74.1
60 and older	24		23	95.8	17	70.8	11	45.8	21	87.5	17	70.8
Grand Total	246		237	96.3	172	69.9	117	47.6	175	71.1	153	62.2

*Other: mixed race individuals, Asians, Alaska natives, Native Hawaiians, Pacific Islanders and unknown

**RNI/Other: risk not identified/perinatal transmission, hemophilia, blood transfusion, and occupational exposure (healthcare workers); Non-MSM: All modes of transmission except MSM and MSM/IDU.

- There were slight disparities between transgender women and transgender men on the continuum of care spectrum. Transgender men were more likely than transgender women to be retained in care in 2014,

HIV among Transgender Persons in the District of Columbia

- By race/ethnicity, there were high rates of linkage to care, but Hispanics had the highest rate of retention in any care in 2014, while white transgender persons had the lowest rates of continuous care in 2014. White transgender persons had the highest proportion of cases who had ever been virally suppressed, while transgender person of "other" race/ethnicity had the highest proportion of viral suppression in 2014.
- Among transgender persons, mode of transmission is classified slightly different than the general population. Here, mode of transmission is classified as IDU, sexual contact, sexual contact/IDU and RNI/Other. Sexual contact includes what was traditionally classified as MSM and heterosexual contact. By mode of transmission, IDU have the highest rates of retention in any care, retention in continuous care in 2014 and viral suppression in 2014.
- By age, cases aged 20-29 at the end of 2013 had the lowest rates of retention in any care and retention in continuous care in 2014 and had one of the lowest rates of viral suppression.
- Of the 74 transgender person that did not receive any care in 2014, majority were transgender women (71.6%), black (85.1%), had sexual contact as a mode of transmission (71.6%) and were between the ages of 20 and 29 at the end of 2013 (35.1%). Over three-quarters (87.8%) of transgender HIV cases who did not receive any care in 2014 had ever been linked to care, 39.2% were engaged in care after 12 or months after HIV diagnosis, 47.3% had ever been virally suppressed and 35.1% were at stage 3 HIV disease at diagnosis.
- Among the 60 transgender cases who have never been virally suppressed, majority were transgender women (66.7%), black (91.7%), had a sexual contact as a mode of transmission (70.0%) and were between the age of 20-29 at the end of 2013 (30.0%). More than half were ever linked to HIV care and were engaged in HIV care more than 12 months after diagnosis (55.0%). More than a third (36.7%) were diagnosed at stage 3 HIV disease.

Stage of HIV Disease

This section provides a summary of patterns in stage 3 (AIDS) infection among HIV positive Persons diagnosed within the District. As outlined in Table 3, current CDC guidelines provide a classification system for assessing the severity of HIV disease based on CD4 cell counts and the presence of specific HIV-related conditions. Stage 3 (AIDS) infection signifies that an HIV positive individual has a compromised immune system (i.e., $CD4 < 200$ cells/ μ L and/or an HIV-related opportunistic infection), thereby increasing their susceptibility to adverse health conditions and symptoms associated with infection. As opposed to the traditional HIV disease dichotomy of HIV-only cases and HIV positive cases with AIDS, the HIV infection staging system provides the opportunity to reclassify individual health status dependent on clinical indicators at a given point in time. This flexibility in classifying HIV disease progression is reflective of current advances in HIV treatment contributing to improvements in disease management and prognoses. The subsequent tables and graphs provide an overview concerning trends in initial stage 3 (AIDS) infection diagnoses among District residents; patterns in disease stage around the time of initial HIV diagnosis; and comparisons in individual disease stage at different points in time since HIV diagnosis.

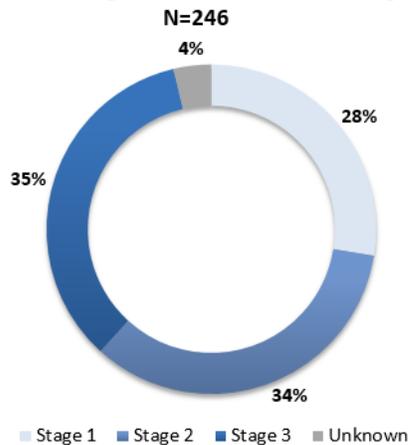
HIV among Transgender Persons in the District of Columbia

Table 3. Stages of HIV Infection

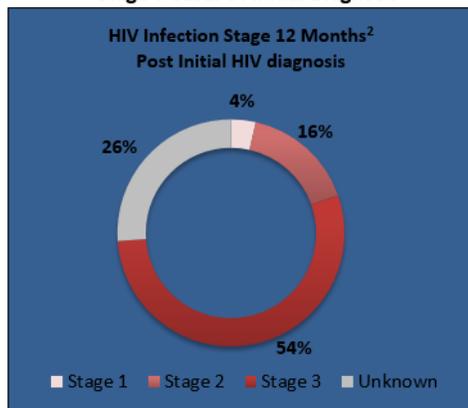
Measure	Definition
Stage 1	CD4 T-cell count of more than 500 cells/ μ L CD4 T-cell percent of more than 29%
Stage 2	CD4 T-cell count of between 200 cells/ μ L and 500 cells/ μ L CD4 T-cell percent of between 14% and 29%
Stage 3 (AIDS)	CD4 T-cell count of less than 200 cells/ μ L CD4 T-cell percent of less than 14% Previously diagnosed AIDS-related conditions
No Info	CD4 test result is unknown

Figure 6. Stage of HIV Disease among Living Transgender Cases at HIV Diagnoses and 12 Months after Diagnosis, District of Columbia, 2013

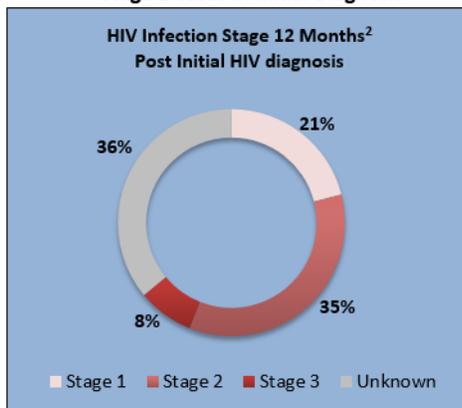
HIV Infection Stage at Initial HIV Disease Diagnosis¹



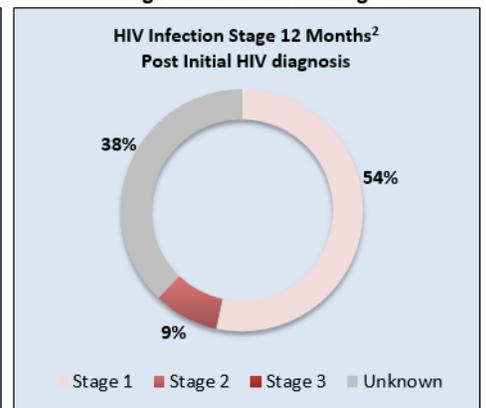
Stage 3 Cases at Initial Diagnosis



Stage 2 Cases at Initial Diagnosis



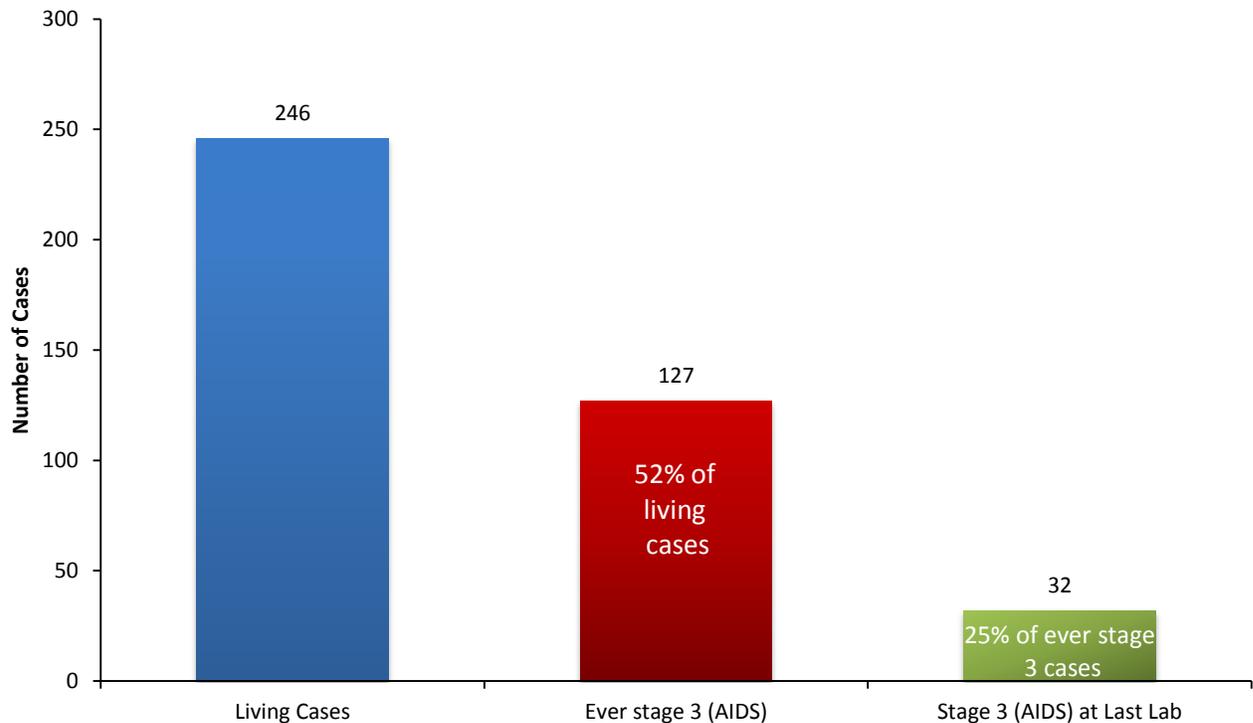
Stage 1 Cases at Initial Diagnosis



¹ Initial stage of HIV infection based on initial CD4 and/or HIV related opportunistic infection information after initial HIV diagnosis.

² Follow-up stage of HIV infection based on CD4 and/or HIV related opportunistic infection information 12 months after initial HIV diagnosis date/

HIV among Transgender Persons in the District of Columbia



- Of the 246 living transgender HIV cases diagnosed in the District, 52% have met the clinical criteria for having Stage 3 disease (AIDS) at some point in time since their initial HIV diagnosis.
- Among HIV positive persons who were ever diagnosed at Stage 3 disease (AIDS), only 25% were documented to have Stage 3 disease (AIDS) based on the last CD4-related laboratory information received by the health department.
- Although subsequent changes in an individual's HIV disease stage may have occurred since their last reported laboratory information, Figure 7 provides evidence that Stage 3 HIV disease is not a static state and that many persons experience improvements in clinical health status after an initial Stage 3 disease diagnosis. Future analyses will focus on better elucidating fluctuations in disease stage among HIV positive persons over time.

Appendix. Understanding HIV Care Surveillance

Primary care visits are not reportable to the DC DOH. However, HIV-related laboratory measures, such as CD4+ T-cell counts and HIV RNA viral loads, are required by DC Municipal code to be reported to HAHSTA by healthcare providers and clinical laboratories. Laboratory measures are used in surveillance to provide approximate measures of access to medical care and HIV-related clinical health status. With improved reporting of laboratory data through the comprehensive electronic laboratory reporting system instituted in 2007, HAHSTA is able to obtain a picture of HIV care among persons living with HIV in the District.

Limitations of Surveillance Data

The Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC) and the Department of Health and Human Services (DHHS) released measures to monitor the stages of HIV care, including diagnosis, linkage to care, retention in care and measurement of viral suppression. The measures reported in this supplement reflect local variations of federal standards revised to reflect the realities of available HIV surveillance data. Due to the nature of these data, there are a number of limitations to consider:

- **Year to year variation**

Metrics are subject to variation by year since they are based on reported surveillance data; fluctuations in timing of data reported to the DC DOH may affect data availability.

- **Moving between stages**

This report is a snapshot of care dynamics in the District and does not reflect movement between stages.

- **Changes in surveillance procedures**

Although instituted in 2007, systematic collection of laboratory data began in 2009; thus, data collected prior to 2009 are not as complete or reliable as data collected since 2009.

- **Missing data**

Care information can only be assessed among persons with reported data. There are some instances where diagnosed cases may not have laboratory data but are included in this report. For these cases, it is unclear whether persons are in care and HAHSTA is not receiving reports of laboratories, or whether a person is truly out of care.

- **Limited extra-jurisdiction data**

While healthcare facilities in the District cater to residents of the greater metropolitan area, DOH surveillance data are currently limited to HIV patients who were established as residents of the District at the time of HIV or AIDS diagnosis.

- **Migration out of the city**

This reports uses as a denominator the number of HIV positive people who were first diagnosed while residents of DC, between 2008 and 2012, and who are still alive. Whether any of these persons are receiving care in other jurisdictions (other than Virginia and Maryland) or whether they have moved out of DC is not known.

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- **Number of lab tests**

HIV positive persons in good health may be less likely to seek care, as compared to those who are in poorer health and require more care. Thus, there may be a trend towards persons with suppressed viral loads and higher CD4 counts to receive primary medical care but skip recommended lab tests. If this is the case, it would result in an underestimate of retention in care.

- **No comparison to other data**

These data should not be compared to other continuum of care presentations. Lack of uniformity of data systems and definitions of care metrics prevent accurate between-jurisdictional assessments. This continuum of care should not be compared to previous supplemental care data, as it evaluates different time periods.

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