Centers for Disease Control and Prevention

MMWR

Morbidity and Mortality Weekly Report

Weekly / Vol. 59 / No. 37

September 24, 2010

National Gay Men's HIV/AIDS Awareness Day — September 27, 2010

National Gay Men's HIV/AIDS Awareness Day is observed each year on September 27 to focus on the disproportionate effects of the human immunodeficiency virus (HIV) epidemic on gay, bisexual, and other men who have sex with men (MSM). In 2007, the estimated HIV diagnosis rate among MSM was 692 per 100,000, which was 44 to 86 times the rate for other men and 40 to 77 times the rate for women (*1*).

Although MSM represent approximately 2% of the U.S. population (*1*), in 2006 they accounted for 57% of all new HIV infections (*2*). From 2005 to 2008, estimated diagnoses of HIV infection increased approximately 17% among MSM in 37 states (*3*). In 2008, black MSM had the highest estimated number of diagnoses of HIV infection, followed by white and Hispanic MSM (*3*). In recent years, new HIV diagnoses have increased significantly among young black MSM (*4*).

CDC supports a range of efforts to reduce HIV infection among MSM. These include HIV prevention services that aim to reduce the risk for acquiring and transmitting HIV and to increase the linkage of infected MSM to treatment. Additional information about these efforts and National Gay Men's HIV/AIDS Awareness Day activities is available at http://www.aids.gov/awareness-days, http://www.cdc.gov/hiv/topics/msm, and http://www.cdc.gov/lgbthealth.

References

1. Purcell DW, Johnson C, Lansky A, et al. Calculating HIV and syphilis rates for risk groups: estimating the national population size of MSM. Presented at the 2010 National STD Prevention Conference, Atlanta, GA; March 10, 2010.
2. Hall HI, Song R, Rhodes P, et al. Estimation of HIV incidence in the United States. JAMA 2008;300:520–9.
3. CDC. HIV surveillance report, 2008. Vol. 20. Atlanta, GA: US Department of Health and Human Services, CDC; 2010.
4. CDC. Trends in HIV/AIDS diagnoses among men who have sex with men—33 states, 2001–2006. MMWR 2008;57:681–6.

Prevalence and Awareness of HIV Infection Among Men Who Have Sex With Men — 21 Cities, United States, 2008

Men who have sex with men (MSM) are at increased risk for infection with human immunodeficiency virus (HIV). In 2006, 57% of new HIV infections in the United States occurred among MSM (*1*). To estimate and monitor risk behaviors, CDC's National HIV Behavioral Surveillance system (NHBS) collects data from metropolitan statistical areas (MSAs) using an anonymous cross-sectional interview of men at venues where MSM congregate, such as bars, clubs, and social organizations. This report summarizes NHBS data from 2008, which indicated that, of 8,153 MSM interviewed and tested in the 21 MSAs participating in NHBS that year, HIV prevalence was 19%, with non-Hispanic blacks having the highest prevalence (28%), followed by Hispanics (18%), non-Hispanic whites (16%), and persons who were multiracial or of other race (17%). Of those who were infected, 44% were unaware of their infection. Men who know their current HIV infection status can be linked to appropriate medical care and prevention services. Once linked to prevention services, men can learn ways to avoid transmitting the virus to others. Young MSM (aged 18–29 years) (63%) and minority MSM (other than non-Hispanic white) (54%) were more likely to be unaware of their HIV infection. Efforts to ensure at least annual HIV testing for MSM should be strengthened, and HIV testing and prevention programs should increase their efforts to reach young and minority MSM.

INSIDE

1208 Racial Differences by Gestational Age in Neonatal Deaths Attributable to Congenital Heart Defects — United States, 2003–2006
1212 Update: Detection of a Verona Integron-Encoded Metallo-Beta-Lactamase in *Klebsiella pneumoniae* — United States, 2010
1213 Announcements

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
www.cdc.gov/mmwr

NHBS is a behavioral surveillance system used to monitor prevalence and trends in 1) HIV-related risk behaviors, 2) HIV testing, and 3) use of HIV prevention services among populations at high risk for acquiring HIV, including MSM, injection-drug users, and heterosexuals at increased risk for HIV infection. Data are collected in annual cycles from one risk group per year so that each group is surveyed once every 3 years. The first cycle of NHBS (among MSM) was conducted in 15 MSAs during 2004–2005; behavioral surveys were conducted in 10 MSAs, and HIV testing in conjunction with the behavioral survey was conducted in five MSAs (*2*). In 2008, NHBS staff members in 21 MSAs collected cross-sectional behavioral risk data and conducted HIV testing among MSM. MSAs were selected based on high prevalence of acquired immunodeficiency syndrome (AIDS); the 21 MSAs included approximately 60% of all prevalent urban U.S. AIDS cases in 2006. MSM were sampled using venue-based, time-space sampling methods. Health department staff members first identified appropriate venues (e.g., bars, clubs, organizations, and street locations) and days and times when men frequented those venues (*3*). Venues and the corresponding day/time periods (VDTs) were chosen randomly each month. Staff members then systematically approached men at the venues (*2*). Men eligible for being interviewed were aged ≥18 years, residents of the MSAs, and able to complete the interview in English or Spanish. After participants gave informed consent, trained interviewers administered a standardized, anonymous questionnaire using a handheld computer. The interview consisted of questions about sex, drug use, HIV testing behaviors, and use of HIV prevention services. All respondents were offered anonymous HIV testing, regardless of self-reported HIV infection status, given the opportunity to receive their test results, and anonymously referred to care when appropriate. HIV testing was performed by collecting blood or oral specimens for either Western blot (WB) or immunofluorescence assay (IFA) confirmatory testing in a laboratory or rapid testing at venues using Food and Drug Administration (FDA)–approved tests for use in nonlaboratory settings. A nonreactive rapid test was considered a definitive negative result; reactive (preliminary positive) rapid test results were considered definitive positive only when confirmed by WB

The *MMWR* series of publications is published by the Office of Surveillance, Epidemiology, and Laboratory Services, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

Suggested citation: Centers for Disease Control and Prevention. [Article title]. MMWR 2010;59:[inclusive page numbers].

Centers for Disease Control and Prevention

Thomas R. Frieden, MD, MPH, *Director*
Harold W. Jaffe, MD, MA, *Associate Director for Science*
James W. Stephens, PhD, *Office of the Associate Director for Science*
Stephen B. Thacker, MD, MSc, *Deputy Director for Surveillance, Epidemiology, and Laboratory Services*

MMWR Editorial and Production Staff

Ronald L. Moolenaar, MD, MPH, *Editor,* MMWR *Series*
John S. Moran, MD, MPH, *Deputy Editor,* MMWR *Series*
Robert A. Gunn, MD, MPH, *Associate Editor,* MMWR *Series*
Teresa F. Rutledge, *Managing Editor,* MMWR *Series*
Douglas W. Weatherwax, *Lead Technical Writer-Editor*
Donald G. Meadows, MA, Jude C. Rutledge, *Writer-Editors*
Martha F. Boyd, *Lead Visual Information Specialist*
Malbea A. LaPete, Stephen R. Spriggs, Terraye M. Starr
Visual Information Specialists
Quang M. Doan, MBA, Phyllis H. King
Information Technology Specialists

MMWR Editorial Board

William L. Roper, MD, MPH, Chapel Hill, NC, *Chairman*
Virginia A. Caine, MD, Indianapolis, IN
Jonathan E. Fielding, MD, MPH, MBA, Los Angeles, CA
David W. Fleming, MD, Seattle, WA
William E. Halperin, MD, DrPH, MPH, Newark, NJ
King K. Holmes, MD, PhD, Seattle, WA
Deborah Holtzman, PhD, Atlanta, GA
John K. Iglehart, Bethesda, MD
Dennis G. Maki, MD, Madison, WI
Patricia Quinlisk, MD, MPH, Des Moines, IA
Patrick L. Remington, MD, MPH, Madison, WI
Barbara K. Rimer, DrPH, Chapel Hill, NC
John V. Rullan, MD, MPH, San Juan, PR
William Schaffner, MD, Nashville, TN
Anne Schuchat, MD, Atlanta, GA
Dixie E. Snider, MD, MPH, Atlanta, GA
John W. Ward, MD, Atlanta, GA

What is already known on this topic?

The greatest number of human immunodeficiency virus (HIV) infections in the United States occur among men who have sex with men (MSM).

What is added by this report?

Data from a convenience sample of MSM in 21 U.S. cities indicated an HIV prevalence of 19% in 2008; 44% of HIV-infected MSM were unaware of their HIV infection, and the highest HIV prevalence and infection unawareness were among young and minority MSM. More than half (55%) of MSM unaware of their infection reported not having an HIV test during the preceding 12 months.

What are the implications for public health practice?

Increased efforts to educate MSM and health-care providers about HIV testing guidelines and to reduce barriers to HIV testing for MSM are necessary; MSM remain a key target for HIV testing and prevention programs.

or IFA. MSM unaware of their HIV infection were defined as those who tested HIV-positive at the time of the interview but reported that the result of their most recent HIV test was negative, indeterminate, or unknown, or that they had never been tested. Men were compensated both for their time participating in the interview and for taking an HIV test.

In 2008, a total of 28,468 men were approached, and 12,325 were screened for participation in NHBS at 626 venues in 21 MSAs. Of men who were screened, 11,074 (90%) were eligible for the survey. Men were excluded from analysis if they did not consent to and complete both the survey and the HIV test (n = 1,558), did not report sex with a man during the preceding 12 months (n = 1,744), had an indeterminate HIV test result (n = 85), or reported being HIV-positive but had a negative NHBS HIV test result (n = 60). These criteria were not mutually exclusive; a total of 2,921 men were excluded from analysis. Of eligible men, 8,153 (74%) were MSM who met criteria for inclusion in this analysis. The median age of the MSM in this report was 32 years (range: 18–85 years); 44% were non-Hispanic white, 25% Hispanic, 23% non-Hispanic black, 2% Asian, 0.8% Native Hawaiian/Pacific Islander, 0.6% American Indian/Alaska Native, and 4% multiracial or other. Thirty-seven percent had a college education or higher, and 30% reported an annual household income <$20,000. Sixty-seven percent of men reported a household size of one. The majority had health insurance (66%) and had visited a health-care provider during the preceding year (76%) (Table 1).

Among the 8,153 MSM tested, 1,562 (19%) tested positive for HIV (range by MSA: 6%–38%). HIV prevalence was 28% among blacks, 18% among Hispanics, and 16% among whites. HIV prevalence increased with increasing age and decreased with increasing education and income (Table 1).

Of the 1,562 HIV-infected MSM, 680 (44%) were unaware of their infection. The proportion who were unaware of their infection was higher among younger than older MSM (Table 1). The proportion unaware was highest among blacks (59%), lowest among whites (26%), and decreased with increasing education and income. Higher proportions of MSM with no health insurance and those who had not visited a health-care provider during the preceding year were unaware of their infection (Table 1). Fifty-five percent of MSM unaware of their infection had not been tested during the preceding 12 months.

The HIV prevalence by age group and race/ethnicity for MSM aged <30 years was highest among black MSM in each age group. The majority of young black and Hispanic MSM in each age group were unaware of their HIV infection (Table 2).

For comparison with a previous NHBS report of MSM HIV prevalence during 2004–2005, which indicated an HIV prevalence of 26% among MSM and an infection unawareness rate of 48% (*4*), five MSAs (Baltimore, Maryland; Los Angeles, California; Miami, Florida; New York, New York; and San Francisco, California) were analyzed separately in the analysis of 2008 data. Results indicated that the overall HIV prevalence was 27%, and 48% of HIV-positive participants were unaware of their infection. HIV prevalence among blacks was 40%; 63% were unaware of their infection. These prevalence rates were similar to those from 2004–2005 NHBS data*; the proportion of MSM unaware of their infection did not increase (Table 3).†

* In New York, HIV prevalence rose between the two periods, but this was primarily caused by an increase in the proportion of participants who were black, Hispanic, or aged ≥40 years.

† Original report was based on preliminary data. Percentages in this report reflect unpublished analyses of final data.

TABLE 1. Prevalence of human immunodeficiency virus (HIV) infection and proportion unaware of HIV infection among men who have sex with men, by selected characteristics — National HIV Behavioral Surveillance System, 21 U.S. cities, 2008

		HIV prevalence			Unaware of HIV Infection		
Characteristic	Total no. tested	No.	(%)	(95% CI*)	No.	(%)	(95% CI)
Age group (yrs)							
18–19	423	28	(7)	(4–9)	21	(75)	(55–89)
20–24	1,466	170	(12)	(10–13)	115	(68)	(61–75)
25–29	1,529	223	(15)	(13–17)	128	(57)	(51–64)
30–39	2,231	470	(21)	(19–23)	214	(46)	(41–50)
40–49	1,712	474	(28)	(26–30)	164	(35)	(30–39)
≥50	792	197	(25)	(22–28)	38	(19)	(14–26)
Race/Ethnicity†							
American Indian/Alaska Native	45	8	(18)	(8–32)	—§	—§	—§
Asian	185	14	(8)	(4–12)	6	(43)	(18–71)
Black, non-Hispanic	1,895	539	(28)	(26–31)	318	(59)	(55–63)
Hispanic	2,045	358	(18)	(16–19)	163	(46)	(40–51)
Native Hawaiian/Pacific Islander	62	11	(18)	(9–30)	5	(45)	(17–77)
White, non-Hispanic	3,580	560	(16)	(15–17)	143	(26)	(22–29)
Other¶	336	72	(21)	(17–26)	42	(58)	(46–70)
Education							
Less than high school diploma	526	132	(25)	(21–29)	68	(52)	(43–60)
High school diploma or equivalent	1,904	446	(23)	(22–25)	236	(53)	(48–58)
Some college or technical college	2,714	565	(21)	(19–22)	230	(41)	(37–45)
College or higher education	3,009	419	(14)	(13–15)	146	(35)	(30–40)
Annual household income†							
≤$19,999	2,416	639	(26)	(25–28)	305	(48)	(44–52)
$20,000–$39,999	2,084	391	(19)	(16–20)	182	(47)	(42–52)
$40,000–$74,999	1,986	302	(15)	(14–17)	117	(39)	(33–45)
≥$75,000	1,557	213	(14)	(12–16)	64	(30)	(24–37)
Sexual identity†							
Heterosexual	96	8	(8)	(4–16)	5	(63)	(25–92)
Bisexual	1,485	273	(18)	(16–20)	173	(63)	(57–69)
Homosexual	6,562	1,279	(19)	(19–21)	501	(39)	(37–42)
Health insurance†							
No	2,722	513	(19)	(17–20)	290	(57)	(52–61)
Yes	5,305	1,019	(19)	(18–20)	379	(37)	(34–40)
Visited health-care provider in past year†							
No	1,940	228	(12)	(10–13)	185	(81)	(75–86)
Yes	6,210	1,334	(21)	(21–23)	495	(37)	(35–40)
Most recent HIV test†							
Never	745	106	(14)	(12–17)	106	(100)	(97–100)
>12 months ago	2,632	843	(32)	(30–34)	262	(31)	(28–34)
≤12 months ago	4,752	605	(13)	(12–14)	306	(51)	(47–55)
Metropolitan statistical area							
Atlanta, Georgia	343	22	(6)	(4–10)	12	(55)	(32–76)
Baltimore, Maryland	447	169	(38)	(33–43)	124	(73)	(66–80)
Boston, Massachusetts	198	24	(12)	(8–18)	7	(29)	(13–51)
Chicago, Illinois	516	93	(18)	(15–22)	49	(53)	(42–63)
Dallas, Texas	461	119	(26)	(22–30)	64	(54)	(44–63)
Denver, Colorado	449	70	(16)	(12–19)	14	(20)	(11–31)
Detroit, Michigan	312	44	(14)	(10–19)	31	(70)	(55–83)
Houston, Texas	436	113	(26)	(22–30)	26	(23)	(16–32)
Los Angeles, California	478	89	(19)	(15–22)	29	(33)	(23–43)
Miami, Florida	526	133	(25)	(22–29)	60	(45)	(37–54)
Nassau-Suffolk, New York	242	19	(8)	(5–12)	5	(26)	(9–51)
New Orleans, Louisiana	354	76	(21)	(17–26)	20	(26)	(17–38)
New York, New York	462	132	(29)	(25–33)	69	(52)	(43–61)
Newark, New Jersey	80	15	(19)	(11–29)	—§	—§	—§
Philadelphia, Pennsylvania	440	48	(11)	(8–14)	34	(71)	(56–83)
San Diego, California	490	87	(18)	(15–21)	35	(40)	(30–51)
San Francisco, California	474	111	(23)	(20–28)	21	(19)	(12–28)
San Juan, Puerto Rico	313	36	(12)	(8–16)	26	(72)	(55–86)
Saint Louis, Missouri	306	42	(14)	(10–18)	14	(33)	(20–50)
Seattle, Washington	352	52	(15)	(11–19)	8	(15)	(7–28)
Washington, DC	474	68	(14)	(11–18)	28	(41)	(29–54)
Total	**8,153**	**1,562**	**(19)**	**(18–20)**	**680**	**(44)**	**(41–46)**

* Confidence interval. Calculated using the Clopper-Pearson method.
† Numbers might not add to total because of missing data.
§ Suppressed because of small cell size (fewer than five).
¶ Includes persons who indicated multiple races or other race.

Reported by

A Smith, MPH, I Miles, ScD, B Le, MD, T Finlayson, PhD, A Oster, MD, E DiNenno, PhD, Div of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, CDC.

Editorial Note

The findings from this analysis corroborate other surveillance data showing that HIV prevalence among MSM remains high, many HIV-infected MSM are unaware that they are infected with HIV, and minority MSM are disproportionately affected by HIV (*5–6*). Because MSM represent the only group with increasing HIV incidence and comprise the largest proportion of new infections (*1*), it is critical to target resources and prevention strategies to MSM. The National HIV/AIDS Strategy[§] emphasizes the importance of improving the impact of HIV prevention efforts for MSM. The NHBS data also underscore the specific need for increased HIV testing efforts for all MSM, especially minority MSM; CDC recently broadened its expanded HIV testing initiative to reach more MSM.[¶]

[§] Additional information available at http://www.whitehouse.gov/administration/eop/onap.

[¶] Additional information available at http://www.cdc.gov/hiv/topics/funding/ps10-10138/index.htm.

TABLE 2. Prevalence of human immunodeficiency virus (HIV) infection and proportion unaware of HIV infection among young men who have sex with men, by age group and race/ethnicity — National HIV Behavioral Surveillance System, 21 U.S. cities, 2008

Characteristic	Total no. tested	HIV prevalence			Unaware of HIV Infection		
		No.	(%)	(95% CI*)	No.	(%)	(95% CI)
18–19 yrs							
Black, non-Hispanic	193	17	(9)	(5–14)	12	(71)	(44–90)
Hispanic	137	5	(4)	(1–8)	4	(80)	(28–100)
White, non-Hispanic	63	—†	—†	—†	—†	—†	—†
20–24 yrs							
Black, non-Hispanic	482	95	(20)	(16–24)	66	(69)	(59–79)
Hispanic	415	33	(8)	(6–11)	24	(73)	(55–87)
White, non-Hispanic	440	29	(7)	(5–9)	16	(55)	(36–74)
25–29 yrs							
Black, non-Hispanic	346	105	(30)	(26–36)	76	(72)	(63–81)
Hispanic	412	50	(12)	(9–16)	27	(54)	(39–68)
White, non-Hispanic	607	46	(8)	(6–10)	14	(30)	(18–46)
Total	**3,098**	**382**	**(12)**	**(11–14)**	**241**	**(63)**	**(58–68)**

* Confidence interval. Calculated using the Clopper-Pearson method.
† Suppressed because of small cell size (fewer than five).

CDC currently recommends that sexually active MSM get tested for HIV at least once per year (*7*). NHBS data demonstrate that 55% of MSM who were unaware of their HIV infection had not had an HIV test during the preceding 12 months. This finding suggests that increased efforts to educate MSM and health-care providers about HIV testing guidelines and to reduce barriers to HIV testing for

TABLE 3. Prevalence of human immunodeficiency virus (HIV) infection and proportion unaware of HIV infection among men who have sex with men, by age group and race/ethnicity — National HIV Behavioral Surveillance System, five U.S. cities, June 2004–April 2005 and 2008

Characteristic	June 2004–April 2005							2008						
	Total no. tested	HIV prevalence			Unaware of HIV Infection			Total no. tested	HIV prevalence			Unaware of HIV Infection		
		No.	(%)	(95% CI*)	No.	(%)	(95% CI)		No.	(%)	(95% CI)	No.	(%)	(95% CI)
Age group (yrs)														
18–19	85	12	(14)	(8–23)	9	(75)	(43–95)	119	13	(11)	(6–18)	9	(69)	(39–91)
20–24	327	48	(15)	(11–19)	39	(81)	(67–91)	406	63	(16)	(12–19)	53	(84)	(73–92)
25–29	306	53	(17)	(13–22)	38	(72)	(58–83)	432	87	(20)	(17–24)	57	(66)	(55–75)
30–39	589	172	(29)	(26–33)	84	(49)	(41–57)	676	192	(28)	(25–32)	93	(48)	(41–56)
40–49	360	138	(38)	(33–44)	39	(28)	(21–37)	521	185	(36)	(31–40)	69	(37)	(30–45)
≥50	99	30	(30)	(22–40)	9	(30)	(15–49)	233	94	(40)	(34–47)	22	(23)	(15–33)
Race/Ethnicity†														
Black, non-Hispanic	441	203	(46)	(41–51)	136	(67)	(60–73)	625	252	(40)	(36–44)	160	(63)	(57–69)
Hispanic	464	82	(18)	(14–22)	41	(50)	(39–61)	846	195	(23)	(20–26)	87	(45)	(38–52)
White, non-Hispanic	616	126	(21)	(17–24)	23	(18)	(12–26)	708	142	(20)	(17–23)	27	(19)	(13–26)
Other§	229	39	(17)	(12–23)	18	(46)	(30–63)	206	45	(22)	(16–28)	29	(64)	(49–78)
Metropolitan statistical area														
Baltimore, Maryland	468	182	(39)	(34–44)	112	(62)	(54–69)	447	169	(38)	(33–43)	124	(73)	(66–80)
Los Angeles, California	376	73	(19)	(16–24)	31	(43)	(31–55)	478	89	(19)	(15–22)	29	(33)	(23–43)
Miami, Florida	225	49	(22)	(17–28)	24	(49)	(34–64)	526	133	(25)	(22–29)	60	(45)	(37–54)
New York, New York	336	62	(19)	(14–23)	32	(52)	(39–65)	462	132	(29)	(25–33)	69	(52)	(43–61)
San Francisco, California	361	87	(24)	(20–29)	19	(22)	(14–32)	474	111	(23)	(20–28)	21	(19)	(12–28)
Total	**1,766**	**453**	**(26)**	**(24–28)**	**218**	**(48)**	**(43–53)**	**2,387**	**634**	**(27)**	**(25–28)**	**303**	**(48)**	**(44–52)**

* Confidence interval. Calculated using the Clopper-Pearson method.
† Numbers might not add to total because of missing data.
§ Because of small sample sizes, category includes American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, and persons who indicated multiple races or other race.

MSM are necessary. Also, because 45% of MSM who were unaware of their infection were tested within the previous 12 months, shorter intervals for testing some MSM might be warranted and should be considered in future recommendations.

This analysis shows racial and economic disparities in both HIV prevalence and awareness of HIV infection. Racial disparities were observed in the youngest age group (18–19 years) and increased with age. CDC is working to decrease these racial disparities and currently funds HIV prevention programs for young, minority MSM.** The economic disparities described in this report are consistent with those reported among heterosexuals participating in NHBS.†† This reinforces the need for targeting prevention efforts to low-income populations, which might reduce HIV infection rates among MSM.

The findings in this report are subject to at least four limitations. First, because the survey was administered by an interviewer, positive HIV status might have been underreported during the interview, given the sensitive nature of the topic, thereby inflating estimates of MSM unaware of their infections. Second, 135 MSM who reported being HIV-positive but who had a negative or indeterminate HIV test result were excluded from analysis because of the possibility that they had false-negative NHBS test results; however, including these men as HIV-positive would have yielded a similar overall HIV prevalence (20% compared with 19%). Third, comparisons of the NHBS-MSM datasets collected during 2004–2005 and 2008 should be made cautiously, because this analysis did not control for demographic differences in the samples, which might have influenced the percentages reported. Finally, these findings are limited to men who frequented MSM-identified venues (most of which were bars [45%] and dance clubs [22%]) during the survey period in 21 MSAs with high AIDS prevalence; the results are not representative of all MSM. A lower HIV prevalence (11.8%) has been reported among MSM in the general U.S. population (*8*).

** Additional information available at http://www.cdcnpin.org/scripts/display/funddisplay.asp?fundnbr=3582.

†† Socioeconomic disparities in HIV rates also have been reported in NHBS among the heterosexual population (Abstract no. WEPPD101, International AIDS Conference, July 2010).

The high proportion of MSM unaware of their HIV infection continues to be a serious public health concern, because these MSM account for the majority of estimated new HIV transmissions in the United States (*9*). Persons aware of their HIV infection often take substantial steps to reduce their risk behaviors, which could reduce HIV transmission (*10*). Whereas many MSM described in this report had not received an HIV test during the preceding 12 months, 45% of MSM who were unaware of their infection did report having an HIV test during the preceding 12 months, indicating they had acquired HIV recently or reported an incorrect HIV test result to the interviewer.

NHBS provides important information to guide and monitor HIV prevention efforts nationally and locally and will be critical for monitoring the impact of the National HIV/AIDS Strategy. The 2008 NHBS data show that MSM remain a key target of strategies to reduce HIV incidence and decrease racial and socioeconomic disparities in the United States.

Acknowledgments

This report is based, in part, on contributions by National HIV Behavioral Surveillance system staff members, including J Taussig, R Gern, T Hoyte, L Salazar, B Hadsock, Atlanta, Georgia; C Flynn, F Sifakis, Baltimore, Maryland; D Isenberg, M Driscoll, E Hurwitz, Boston, Massachusetts; N Prachand, N Benbow, Chicago, Illinois; S Melville, R Yeager, A Sayegh, J Dyer, A Novoa, Dallas, Texas; M Thrun, A Al-Tayyib, R Wilmoth, Denver, Colorado; E Higgins, V Griffin, E Mokotoff, Detroit, Michigan; M Wolverton, J Risser, H Rehman, Houston, Texas; T Bingham, E Sey, Los Angeles, California; M LaLota, L Metsch, D Beck, D Forrest, G Cardenas, Miami, Florida; C Nemeth, C-A Watson, Nassau-Suffolk, New York; WT Robinson, D Gruber, New Orleans, Louisiana; C Murrill, A Neaigus, S Jenness, H Hagan, T Wendel, New York, New York; H Cross, B Bolden, S D'Errico, Newark, New Jersey; K Brady, A Kirkland, Philadelphia, Pennsylvania; V Miguelino, A Velasco, San Diego, California; H Raymond, W McFarland, San Francisco, California; SM De León, Y Rolón-Colón, San Juan, Puerto Rico; M Courogen, H Thiede, N Snyder, R Burt, Seattle, Washington; M Herbert, Y Friedberg, D Wrigley, J Fisher, St. Louis, Missouri; and P Cunningham, M Sansone, T West-Ojo, M Magnus, I Kuo, District of Columbia.

References

1. Hall HI, Song R, Rhodes P, et al. Estimation of HIV incidence in the United States. JAMA 2008;300:520–9.
2. MacKellar DA, Gallagher K, Finlayson T, Sanchez T, Lansky A, Sullivan P. Surveillance of HIV risk and prevention behaviors of men who have sex with men—a national application of venue-based, time-space sampling. Public Health Rep 2007;122:39–47.
3. Allen D, Finlayson T, Abdul-Quader A, Lansky A. The role of formative research in the National HIV Behavioral Surveillance System. Public Health Rep 2009;124:26–33.
4. CDC. HIV prevalence, unrecognized infection, and HIV testing among men who have sex with men—five U.S. cities, June 2004–April 2005. MMWR 2005;54:597–601.
5. Campsmith M, Rhodes P, Hall I, Green T. Undiagnosed HIV prevalence among adult and adolescents in the United States at the end of 2006. J Acquir Immune Defic Syndr 2010;53:619–24.
6. CDC. Cases of HIV infection and AIDS in the United States and dependent areas, 2007. HIV/AIDS Surveillance Report 2009;19.
7. CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. MMWR 2006;55(No. RR-14).
8. Fujie X, Sternberg M, Markowitz L. Men who have sex with men in the United States: demographic and behavioral characteristics and prevalence of HIV and HSV-2 infection. Sex Transm Dis 2010;37:399–405.
9. Marks G, Crepaz N, Janssen RS. Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. AIDS 2006;20:1447–50.
10. Marks G, Crepaz N, Senterfitt JW, et al. Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programs. J Acquir Immune Defic Syndr 2005;39:446–53.