



National HIV Surveillance System (NHSS)


For Everyone
[MAY 18, 2026](#)

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AT A GLANCE

The National HIV Surveillance System (NHSS) is the primary source of HIV data for monitoring cases of HIV infection in the United States and 7 territories and freely associated states (American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, Republic of the Marshall Islands, Republic of Palau, and U.S. Virgin Islands). The data are reported by laboratory and health care providers to state or local surveillance programs, who in turn report the data to CDC.



How NHSS data are collected

Surveillance programs of local, territorial, and state health departments gather information on demographic characteristics (sex, race/ethnicity, age, and place of diagnosis), transmission category (mode of exposure), and all test results indicative of HIV infection and for monitoring stage of disease (viral load and CD4 count and percent).

Information collected includes routine reporting of laboratory tests for HIV to the health department using a standard confidential case report form or via direct reporting from the laboratory. This information is then transmitted electronically, without personal identifiers, to CDC as part of the NHSS.

How NHSS data are used

Data are used to

- monitor the distribution and transmission of HIV,
- plan and evaluate prevention and care programs,
- allocate resources,
- inform policy development, and
- identify and respond to rapid transmission of HIV.

Current data releases

- [HIV Diagnoses, Deaths, and Prevalence](#)
- [Estimated HIV Incidence and Prevalence](#)
- [National HIV Prevention and Care Objectives](#)

- [Social Determinants of Health](#)
- [HIV and AIDS Data through December 2023: Provided for the Ryan White HIV/AIDS Program, for Fiscal Year 2025](#)

Previous data releases

- [Previous data releases on CDC Stacks](#)
- [CDC Archive](#)
- [NCHHSTP Atlas Plus](#)

Technical notes

Surveillance of HIV infection

The Centers for Disease Control and Prevention (CDC) collects, analyzes, and disseminates case surveillance data on HIV diagnoses in CDC’s National HIV Surveillance System (NHSS); these data are one of the nation’s primary sources of information on HIV in the United States. HIV surveillance data are reported to NHSS from state, local, and territorial HIV surveillance programs, and data are subsequently transmitted to CDC without personal identifiers^[1]. The data are from all 50 states, the District of Columbia, and 7 U.S. territories and freely associated states (American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, Republic of the Marshall Islands, Republic of Palau, and the U.S. Virgin Islands) in which laws or regulations require or allow confidential reporting to the jurisdiction (not to CDC), by name, for all persons (adults, adolescents, and children) with confirmed HIV diagnoses, including stage 3 (acquired immunodeficiency syndrome [AIDS]) classification. Although stage 3 (AIDS) cases have been reported to CDC since 1981, the date of implementation of HIV infection reporting has differed from jurisdiction to jurisdiction. All states, the District of Columbia, and 6 U.S. territories and freely associated states had fully implemented name-based HIV infection reporting by April 2008. CDC began receiving data from the Republic of the Marshall Islands in 2023, after they established confidential HIV case surveillance.

Data releases

Data based on a ≥ 12-month reporting delay are considered provisional and subject to change as additional reports are submitted for HIV cases and HIV surveillance data quality improves with further evaluation of the surveillance system and data repository. Data based on an NHSS dataset created before a 12-month reporting delay has been reached are considered preliminary and are also subject to change. The exception is death data, which are considered preliminary unless based on a ≥ 18-month reporting delay. Because reporting delays can impact the reliability of surveillance data, caution should be applied when interpreting the results. For example, the number of HIV diagnoses for a given year may be lower in early data releases; however, fluctuations in the number of diagnoses for a calendar year typically diminish after 2 to 3 years of reporting. Evaluations of surveillance data have shown that most diagnoses are reported within the year of diagnosis, and nearly all are reported by the end of the following year (Unpublished data based on cases reported to the NHSS through December 2025).

Data re-release agreements between CDC and state, local, and territorial HIV surveillance programs require specific levels of cell suppression at the state and county level to protect personally identifiable information. Data released by CDC may not be directly comparable to data published by individual jurisdictions because CDC deduplicates cases at the national level and applies statistical adjustments to account for missing transmission category information.

Stages of HIV infection — Case definitions

Both the 2008 and 2014 HIV case definitions are used to classify HIV infection among persons aged ≥ 13 years and among children < 13 years^[2] ^[3]. The 2008 case definition is used to classify cases diagnosed through 2013, and the 2014 case definition is used to classify cases diagnosed in 2014 and later.

Definitions and data specifications

HIV diagnoses

An HIV diagnosis is defined as a diagnosis of HIV infection regardless of stage of disease (stage 0, 1, 2, 3 [AIDS], or unknown) and refers to all persons with a diagnosis of HIV infection. Data on HIV diagnoses are presented by date of diagnosis rather than by the date of report to NHSS.

Deaths (any cause and HIV-related)

Available death data include deaths among persons with diagnosed HIV from any cause, which may or may not be related to HIV, as well as HIV-related deaths based on underlying cause of death. HIV-related deaths include deaths with an underlying cause with an International Classification of Diseases, Tenth Revision code of B20–B24, O98.7, or R75. Non–HIV-related deaths include all other deaths with a known underlying cause. Persons reported to NHSS are assumed to be alive unless their deaths have been reported to CDC.

Geographic death data are based on residence at death. When residence at death is not available, the state where death occurred is used; when neither is available, the most recent known address on or before the date of death is used. Death data are subject to an 18-month reporting

delay to allow for complete reporting to CDC, and data for the most recent year are considered preliminary. In jurisdictions with incomplete reporting, death data should be interpreted with caution.

Diagnosed prevalence (persons living with diagnosed HIV)

Prevalence data reflect the number of persons living with diagnosed HIV, regardless of stage of disease, at the end of a specified year. Geographic prevalence data are based on most recent known address as of the end of the specified year. Because prevalence numbers rely on complete death reporting, data for the most recent year may be affected by delays in reporting of deaths and should be interpreted with caution.

Estimated HIV incidence and prevalence (diagnosed and undiagnosed)

Estimated HIV incidence represents the estimated number of new HIV infections occurring among persons aged ≥ 13 years during a specified year. Estimated HIV prevalence represents the estimated number of persons aged ≥ 13 years living with HIV infection (diagnosed and undiagnosed) at the end of a specified year.

Estimated HIV incidence and prevalence are derived using a CD4-based depletion model of disease progression. The model applies the first CD4 test result reported at or after HIV diagnosis to estimate the date of HIV infection and the delay from infection to diagnosis. See Technical Notes of [HIV Surveillance Supplemental Report](#) (Volume 29, Number 1) for details on CD4-based model for estimating HIV incidence and prevalence [\[4\]](#).

Important Note:

In late 2025, CDC formed a workgroup to assess the impact of COVID-19-related adjustments to its HIV incidence model. The workgroup found that HIV testing and diagnoses had returned to pre-COVID levels and recommended that COVID-related adjustments to the model be discontinued. In response, CDC has paused the publication of HIV incidence estimates to implement these recommendations and evaluate whether additional adjustments could further strengthen the model. Routine evaluation helps ensure that model assumptions remain up to date, that changes in the HIV prevention and care landscape are accounted for, and that the model continues to yield the strongest possible estimates of HIV incidence in the United States. CDC plans to resume publication of HIV incidence estimates in 2027, after all updates have been evaluated and validated. Because pre-exposure prophylaxis (PrEP) coverage and knowledge of HIV status indicators rely on HIV incidence, these data will be published when HIV incidence estimates have been updated.

Monitoring HIV care outcomes

Laboratory reporting

For analyses of HIV care outcomes (i.e., linkage to HIV medical care, receipt of HIV medical care, and HIV viral suppression) prior to 2023, data were released only for jurisdictions that met NHSS laboratory reporting requirements for complete reporting of CD4 and viral load test results. Consequently, the number of jurisdictions included in national and regional analyses vary across those years. Beginning in 2023, national and regional data releases included data from all 50 states and the District of Columbia. Idaho does not require mandatory reporting of all CD4 and viral load test results; therefore, its data are included in national and regional analyses but are not presented in jurisdiction-level tables. Data for Puerto Rico are not included in national and regional analyses but are presented in jurisdiction-level tables. Data for Guam are not included due to small case numbers. Data for the remaining 5 U.S. territories and associated states are not included in national or jurisdiction-level tables because they do not require mandatory reporting of all CD4 and viral load test results. Care outcome data should be interpreted with caution for jurisdictions with incomplete laboratory reporting for the specified year.

Stage of disease at time of diagnosis

Stages of HIV infection are defined according to the 2014 HIV surveillance case definition and are based on age-specific CD4 lymphocyte counts or percentages or documentation of an AIDS-defining condition [\[3\]](#).

Because complete staging depends on comprehensive laboratory reporting, stage of disease at diagnosis is calculated only for jurisdictions with complete CD4 reporting for the specified year. However, stage 3 (AIDS) classification is available for all jurisdictions. Data on persons with diagnosed HIV, stage 3 (AIDS) include persons whose stage of disease has ever been classified as stage 3 (AIDS). These data do not necessarily reflect a person's current stage of disease.

Stage of disease at time of diagnosis (i.e., HIV infection, stage 0, 1, 2, 3 [AIDS], or unknown) is determined by using the first CD4 test result or documentation of an AIDS-defining condition within 3 months of diagnosis date (including diagnosis on the same day as the CD4 test) during the reported year, unless documentation indicated stage 0. If ≥ 2 events occur during the same month and could qualify as the "first" event, the following hierarchy is applied:

- If an AIDS-defining condition was documented, it is used, regardless of whether a CD4 count or CD4 percentage are also reported.
- If an AIDS-defining condition is not documented and both a CD4 count and CD4 percentage are reported, the CD4 count is used.
- If an AIDS-defining condition is not documented and >1 CD4 count is reported, the lowest CD4 count (indicative of the most severe disease state) is used.
- If an AIDS-defining condition is not documented and no CD4 count is reported but a CD4 percentage is reported, the CD4 percentage is used. If > 1 CD4 percentage is reported, the lowest CD4 percentage (indicative of the most severe disease state) is used.

For stage of disease at time of diagnosis, HIV is classified as "stage unknown" if the month of HIV diagnosis is missing or if, > 3 months after diagnosis, neither a CD4 count nor CD4 percentage are reported and no AIDS-defining condition is documented.

Linkage to HIV medical care

Linkage to HIV medical care within 1 month of HIV diagnosis is measured by documentation of ≥ 1 CD4 (count or percentage) or viral load test performed within 1 month of HIV diagnosis, including tests performed on the same date as the date of diagnosis. Data on linkage to HIV medical care are based on persons with HIV diagnosed during the specified year. The month and year of the earliest HIV-positive test result reported to the surveillance system were used to determine the diagnosis date. Data are excluded for cases where the month of diagnosis is missing.

Receipt of and retention in HIV medical care

Receipt of any HIV medical care is measured by documentation of ≥ 1 CD4 or viral load test performed during the specified year. Retention in care (receipt of continuous HIV medical care) is measured by documentation of ≥ 2 CD4 or viral load tests performed ≥ 3 months apart during the specified year. Data on receipt of HIV medical care and retention in care are based on persons with HIV diagnosed by the end of the calendar year prior to the specified year who were alive at the end of that specified year. Test results are excluded if the month of the specimen collection is missing.

Viral suppression

Viral suppression within 6 months of diagnosis is measured among persons with HIV diagnosed during the specified year. Viral suppression is defined as a viral load result of < 200 copies/mL at any viral load test performed within 6 months of an HIV diagnosis made during the specified year. The cutoff value of < 200 copies/mL is based on the definition of virologic failure as a viral load of ≥ 200 copies/mL. Test results are excluded if the month of diagnosis or month of the specimen collection is missing.

Viral suppression is measured among persons with HIV diagnosed by the end of the calendar year prior to the specified year who were alive at the end of that specified year. Viral suppression is defined as a viral load result of < 200 copies/mL at the most recent viral load test during the specified year. If multiple viral load tests are performed on the same day and could qualify as "most recent," a viral load result of < 200 copies/mL is selected. If the numerical viral load result is missing or reported as a logarithmic value, the interpretation of the result (e.g., *below limit, not detected*) is used to determine viral suppression. Test results are excluded if the month of the specimen collection is missing.

Survival analyses

The Kaplan-Meier method is used to estimate the probability of survival for > 3 years (36 months) among persons with diagnosed HIV and among persons whose stage of disease has ever been classified as stage 3 (AIDS). To allow > 3 years from the time of HIV diagnosis to a death date on or before the end of the most recent data year, analyses are limited to data on persons whose HIV diagnosis or stage 3 (AIDS) classification occurred 3–8 years before the most recent data year. The results of survival analyses are not presented for areas with < 100 diagnoses per year (i.e., < 600 during the 6-year period) because results are unstable.

Demographic information

Age

For NHSS data, age assignments are based on the following:

- For diagnosis-related data, based on the person's age at the time of HIV diagnosis.
- For death-related data, determined by the person's age at time of death.
- For prevalence-related data, based on age at the end of the specified year.
- For incidence-related data, based on age at HIV infection.

Sex

Sex is defined as the biological and physiological characteristics that distinguish individuals as male or female.

Race and ethnicity

Race and ethnicity data are collected using federal standards set by the Office of Management and Budget. Race categories include American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, and White. Persons may be reported in more than one race category (multiracial).

Ethnicity is collected separately and categorized as Hispanic or Latino or not Hispanic or Latino. Hispanic or Latino persons can be of any race. In NHSS data reporting, persons described by race are not Hispanic or Latino. Persons who did not report Hispanic or Latino ethnicity were categorized by race; however, persons with unknown ethnicity may also be included in race categories.

Race categories have changed over time. Before 2003, Asian and Pacific Islander were reported as a single category. In current data, these groups are reported separately. As a result, a small number of cases may still be classified under the combined category, depending on when they were reported [\[5\]](#).

Transmission category

Transmission category is classified based on a hierarchy of the risk factors most likely responsible for HIV transmission; classification is determined based on the person's sex. For surveillance purposes, a diagnosis of HIV is counted only once in the hierarchy of transmission categories [\[6\]](#). Persons aged ≥ 13 years with more than 1 reported risk factor for HIV are classified in the transmission category listed first in the hierarchy. The exception is male-to-male sexual contact *and* injection drug use; this group makes up a separate transmission category.

Hierarchical categories

- **Male-to-male sexual contact (MMSC):** includes males who have had sexual contact with other males, and males who have had sexual contact with both males and females.
- **Injection drug use (IDU):** includes persons who injected nonprescription drugs or who injected prescription drugs for nonmedical purposes. Also includes injection of drugs prescribed to persons if there is evidence that injection equipment was shared (e.g., syringes, needles, cookers).
- **Male-to-male sexual contact *and* injection drug use (MMSC/IDU):** includes males who have had sexual contact with other males, and males who have had sexual contact with both males and females, in addition to males who injected nonprescription drugs or who injected prescription drugs for nonmedical purposes.
- **Heterosexual contact:** includes persons who have ever had heterosexual contact with a person known to have, or with a risk factor for, HIV.
- **Perinatal:** includes persons who acquired HIV through mother-to-child transmission (i.e., during pregnancy, childbirth, breastfeeding, or when receiving premasticated/prechewed food).
- **Other:** includes persons with other risk factors, including hemophilia, blood transfusion, and persons whose risk factor was not reported or not identified.

Because a substantial proportion of cases of HIV are reported to CDC without an identified risk factor, multiple imputation is used to assign a transmission category to these cases [\[6\]](#). Multiple imputation is a statistical approach in which each missing transmission category is replaced with a set of plausible values that represent the uncertainty about the true, but missing, value [\[7\]](#). Each resulting data set containing the plausible values is analyzed by using standard procedures, and the results from these analyses are then combined to produce the results. Because data have been imputed or statistically adjusted to account for missing transmission category, manual calculations of reported data by transmission category are inaccurate and discouraged. In data releases that display transmission categories, multiple imputation is used for persons aged ≥ 13 years, but not for children < 13 years (because the number of cases in children is small, missing transmission categories are not imputed).

Geographic designations

Area of residence

Data by area of residence reflect the following:

- For diagnoses-related data, address at the time of HIV diagnosis or stage 3 (AIDS) classification
- For death-related data, area of residence is based on residence at death. When information on residence at death is not available, the state where a person's death occurred is used
- For prevalence-related data, area of residence is based on most recent known address as of December 31 of the specified year

U.S. Census regions

Data by region reflect the following:

- For diagnosis-related data, region is based on address at the time of diagnosis of HIV
- For death-related data, region is based on residence at death. When information on residence at death is not available, the state where a person's death occurred is used
- For prevalence-related data, region is based on most recent known address as of the end of the specified year

The 4 regions of residence and 7 U.S. territories and freely associated states used in this report are defined by the U.S. Census Bureau as follows [\[8\]](#):

- **Northeast:** Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont
- **Midwest:** Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin
- **South:** Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia
- **West:** Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming

U.S. territories and freely associated states: American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, Republic of the Marshall Islands, the Republic of Palau, and the U.S. Virgin Islands

Metropolitan statistical areas/population area of residence

Metropolitan statistical areas (MSAs) data are presented for populations of 500,000 or more. The MSAs listed in MSA-related tables were defined according to OMB [9]. In 2022, U.S. Census Bureau county-level data transitioned from 8 counties to 9 planning regions in Connecticut [10].

Ending the HIV Epidemic in the U.S. (EHE) Phase I jurisdictions

To accelerate action to end HIV, HHS has proposed a plan to reduce new HIV infections in the United States. The EHE initiative, Phase I, implements high-impact HIV prevention, care, treatment, and outbreak response strategies in 48 counties, the District of Columbia, San Juan, Puerto Rico, and 7 states with a substantial rural HIV burden [11]. The goal of the initiative is to reduce new HIV infections by 75% in 5 years, and by 90% in 10 years. For a list of the EHE Phase I jurisdictions, see <https://www.cdc.gov/ehe/php/jurisdictions-plans>.

Rates

Rates are used to compare HIV diagnoses, deaths, and prevalence across populations. Rates are calculated for specific demographic groups using population estimates by age, sex, and race and ethnicity, when available.

- Rates per 100,000 population are calculated by dividing the number of diagnoses, deaths, or prevalent cases in a given year by the corresponding population and multiplying by 100,000. Population denominators are derived from U.S. Census Bureau vintage estimates for the most recent year of surveillance data presented for the 50 states, the District of Columbia, and Puerto Rico, and from the U.S. Census Bureau's International Data Base for U.S. territories and freely associated states.
- Rates of perinatally acquired HIV are calculated as the number of cases of HIV acquired at birth divided by the total number of live births, multiplied by 100,000.
- When reporting data on deaths, rates are calculated in three ways:
 - **Rates of deaths per 100,000 population:** Each rate was calculated by dividing the total number of deaths during the calendar year by the population for that calendar year and then multiplying the result by 100,000.
 - **Rates of deaths per 1,000 persons living with diagnosed HIV or living with HIV disease ever classified as stage 3 (AIDS):** Rates were calculated by dividing the total number of deaths among persons with diagnosed HIV (or with HIV classified as stage 3 [AIDS]) during the calendar year by the sum of the number of persons living with an HIV diagnosis (or with HIV classified as stage 3 [AIDS]) at the end of the previous calendar year plus the number of HIV diagnoses (or stage 3 [AIDS] classifications) during the current calendar year; the result was then multiplied by 1,000.
 - **Age-adjusted rates of deaths per 100,000 population and per 1,000 persons living with diagnosed HIV or living with HIV disease ever classified as stage 3 (AIDS):** Age-adjusted rates are provided by area of residence in addition to crude rates. A standard population distribution was used to adjust death rates per 100,000 population and per 1,000 persons living with diagnosed HIV (or with HIV disease ever classified as stage 3 [AIDS]). Age-adjusted rates represent the rates that would have existed if the age distribution of the designated population and the age distribution of the standard population were the same. The use of the U.S. 2000 standard population to calculate age-adjusted rates, is consistent with recommendations from the National Center for Health Statistics [12] [13].
- Rates are not calculated by race/ethnicity for the 7 U.S. territories and freely associated states because the U.S. Census Bureau does not collect information for all 7 jurisdictions.
- Rates are not calculated by transmission category because denominator data are not available from the U.S. Census Bureau, the source of denominator data used to calculate all rates provided in data releases.

Limitations of HIV surveillance data

- **Testing patterns.** The scope to which routine testing is offered to specific groups and the availability of, and access to, medical care and testing services may influence diagnosis trends.
- **Case reporting.** HIV surveillance programs collect HIV surveillance data in a standardized way; however, surveillance practices may vary among jurisdictions. For example, not all persons who received a positive HIV test result may be registered in the confidential, name-based HIV registries of HIV surveillance programs due to the use of anonymous HIV testing and home HIV self-testing. NHSS data provide minimum counts of persons for whom HIV has been diagnosed and reported to the HIV surveillance program. Consequently, these reporting delays may result in lower numbers than those presented in later reports; however, fluctuations in the number of diagnoses for a calendar year typically subside after two to three years of reporting.
- **Cases with no reported or identified risk factor.** A substantial proportion of cases in NHSS are reported without any, or insufficient, patient history information to be classified into a known transmission category with variations across HIV surveillance programs. Multiple imputation is used to assign a transmission category to cases reported without any, or insufficient, risk information to be classified into a known transmission category [7]; thus, data on transmission category presented in national products do not directly reflect collected case data. Multiple imputation is not used for pediatric cases. If minimum criteria are met, HIV surveillance programs can opt to use a multiple imputation approach.
- **Duplicates.** Case records are routinely reviewed for potential duplicate entries at both the state, local, and territorial- and national-level, and resolution is completed within and between states. However, there may be cases that appear more than once in the national dataset that have

not been deemed duplicates; likewise, there may be cases that have been determined to be duplicates but are unique cases.

- **COVID-19.** HIV diagnosis data for the year 2020 should be interpreted with caution due to the onset of the COVID-19 pandemic. The pandemic substantially disrupted access to HIV testing services, HIV medical care, and PrEP-related services, as well as surveillance activities in state and local jurisdictions. Because these disruptions extended beyond 2020, potential impact of COVID-19–related service interruptions on HIV data for 2020 and subsequent years should be considered.

Resources

Core Indicators for Monitoring the Ending the HIV Epidemic Initiative, Preliminary Data Through December 2025 EXCEL	Download
HIV diagnosis and care linkage data, 2017–2024, with preliminary 2025 CDC reports.	
2024 HIV Stage 3 (AIDS) Figures PPT	Download
This PowerPoint slide set includes charts and figures of 2024 data on HIV Stage 3 (AIDS)	
HIV Diagnoses, Deaths, and Prevalence 2024 Data Release Tables EXCEL	Download
This spreadsheet includes tables for the 2024 HIV surveillance data release.	
HIV Diagnoses, Deaths, and Prevalence 2024 Data Release Figures PPT	Download
This PowerPoint slide set includes charts and figures for the 2024 HIV Surveillance data release.	
2024 National HIV Prevention and Care Objectives Data Release Tables EXCEL	Download
Tables for the HIV Data Release: National HIV Prevention and Care Objectives, 2024	
2024 National HIV Prevention and Care Objectives Data Release Figures PPT	Download
This PowerPoint slide set includes charts and figures for the 2024 HIV Monitoring Data Release	
SDOH Report Tables, 2023 EXCEL	Download
Tables for the HIV Supplemental Surveillance Report: SDOH and Selected Care Outcomes	
SDOH Report Figures, 2023 PPT	Download
This PowerPoint slide set includes charts and figures for the 2023 SDOH Report	
HIV Mortality, 2023 PPT	Download
This PowerPoint slide set presents trends in rates and distributions of deaths in the United States,...	
Assurance of Confidentiality Statement for the National HIV Surveillance System (NHSS) and Surveillance Related Data PDF	Download
This is CDC's assurance of confidentiality statement for the National HIV Surveillance System and the...	
Integrated Guidance for Developing HIV Epidemiologic Profiles PDF	Download
This guidance document assists with compiling and interpreting HIV prevention, surveillance, and care...	
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SOURCES AND PAGE INFO

CONTENT SOURCE:

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