Executive Summary

Abbreviations Used

AIDS – Acquired Immune Deficiency Syndrome
ADAP–AIDS Drugs Assistance Program
CCCHAP – Community Cooperative Council on HIV/AIDS Prevention
CD4–Cluster of Differentiation 4
CDC–Centers for Disease Control and Prevention
CTR–HIV Counseling, Testing and Referral
DIS – Disease Intervention Specialist
eHARS– Enhanced HIV and AIDS Reporting System
HBV–Hepatitis B Virus
HCV–Hepatitis C Virus
HIV – Human Immunodeficiency Virus
HRSA–Health Resources and Services Administration
IDU – Injection Drug Use(r)
MCHACP–Minnesota Council for HIV/AIDS Care and Prevention
MDH – Minnesota Department of Health
MSM – Men Who Have Sex with Men
PLWHA–People Living with HIV/AIDS
STD – Sexually Transmitted Disease
STI – Sexually Transmitted Infection
TB–Tuberculosis
TGA – Transitional Grant Area
VL–Viral Load

Purpose

The epidemiological (epi) profile presents data on the HIV epidemic in the state of Minnesota. The profile is intended to give the Minnesota Council for HIV/AIDS Care and Prevention (MCHACP) a thorough understanding of the epidemic in our state. By showing who is becoming infected and who is living with the disease, the epi profile helps identify the people who are in need of prevention and care services, both those who are infected and those at risk. The epi profile serves as a starting point for MCHACP in their consideration of which prevention and care services are needed.
The profile presents data for the state as a whole, the 7-county metropolitan area\(^1\), and the Minneapolis-St. Paul Transitional Grant Area\(^2\) (TGA), consisting of eleven Minnesota counties and two Wisconsin counties.

Prevention funds are prioritized and distributed based on the epidemiology in the state, whereas funds for services are prioritized and distributed based both on the epidemiology in the TGA (Part A) and in the State (Part B).

**Data Limitations**

MDH has collected AIDS data since 1982 and HIV data since 1985. Data for the epi profile are mainly obtained through the HIV/AIDS surveillance system (eHARS) at MDH. These data are mostly obtained through passive surveillance from providers and consist of reports of confirmatory tests, viral loads and CD4 counts, in addition to case reports and interview data that include information on risk factors and behavior. Data on risk factors and demographics rely heavily on patient and provider reporting. The data in this report are from both interviewed and non-interviewed cases. Cases living with HIV/AIDS include persons currently living in Minnesota regardless of residence of diagnosis, and therefore includes persons diagnosed in Minnesota as well as those diagnosed outside of Minnesota, but have since moved to the state. However, these analyses do not include persons diagnosed in Minnesota but are known to no longer reside in the state, or who known to have died. The analyses also do not include persons incarcerated at federal correctional facilities in Minnesota.

Additional data on reportable bacterial STDs, viral hepatitis and TB were obtained from the MDH STD Surveillance System, MDH Viral Hepatitis Surveillance System, and MDH TB Surveillance System, respectively.

**INTRODUCTION**

More people than ever are living with HIV/AIDS in Minnesota due to both the introduction of new therapies that have slowed the progression of disease for many and, unfortunately, a sustained number of new infections diagnosed each year. In June of 2015, an estimate of the number of HIV positive people who are unaware of their status by state was published by the Centers for Disease Control and Prevention (CDC). This publication estimates that there are 1,200 people living with HIV in Minnesota that have yet to be tested and diagnosed with the infection\(^3\). Given the number of people who are living with undiagnosed HIV in Minnesota, it is likely that the state will continue to see a stable if not increasing number of diagnoses each year if testing is increased and these infections are diagnosed. Therefore, the number of new diagnoses alone should not be the only measured used to assess the state of HIV in Minnesota. Rather, a more

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\(^1\) The 7-county metropolitan area includes the following Minnesota counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington.

\(^2\) The Minneapolis-St. Paul TGA includes the following counties: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright in Minnesota and Pierce and St. Croix in Wisconsin.

A comprehensive approach to evaluating HIV prevention and care in Minnesota is to look at the ratio of new diagnoses to the increase in the number of people who achieve viral suppression. If there is a greater increase in the number of people achieving viral suppression than the number of people diagnosed with HIV each year, then we can begin to turn the curve on the HIV epidemic in Minnesota. As of 2014, this ratio was 1.05 (or slightly more people were diagnosed with HIV than the increase in viral suppression). With an average of 300 new cases of HIV reported each year in Minnesota, getting to a ratio of less than 1.0 would require more than 300 person, either newly or previously diagnosed to start or resume treatment and achieve viral suppression.

**SUMMARY OF DATA**

The HIV epidemic in Minnesota is driven by sexual exposure. Among men, MSM represent the primary mode of exposure. Among females, heterosexual contact accounts for the vast majority of living and new cases.

The HIV epidemic in Minnesota affects racial and ethnic minorities disproportionately, especially African Americans, who are over represented in every risk group. While the emerging epidemic among African-born persons seems to be leveling off, Minnesota continues to see an increasing number of living cases among foreign-born persons. These disparities have significant implications for both prevention and care activities.

Adolescents and young adults (ages 13-24) represent a small percentage of living cases however they have represented an increasing proportion of new cases in the past decade.

While HIV/AIDS continues to be geographically centered in the Twin Cities metropolitan area, injection drug users and heterosexual people living with HIV/AIDS appear to be more likely than other groups to live in Greater Minnesota than within the TGA.

Over the past decade the HIV epidemic in Minnesota has changed in several ways, both when looking at new infections and persons living with HIV/AIDS. The population living with HIV has become more racially, ethnically, culturally and linguistically diverse, which will pose additional challenges to both prevention and service providers. The success of antiretroviral medications has not only extended the life of those recently diagnosed, but also of those diagnosed long ago, which is reflected in the “aging” of those living with HIV/AIDS.