

Companion Text for the Slide Set: ***Minnesota HIV/AIDS Prevalence & Mortality Report, 2003***

INTRODUCTION

The *Minnesota HIV/AIDS Prevalence & Mortality Report, 2003* contains estimates of HIV/AIDS prevalence (the number of persons living with HIV or AIDS) and mortality in Minnesota. These estimates can be used to help educate, plan for HIV/AIDS services and develop policy.

Data Source

The data in this report are based on confidential case reports collected through the Minnesota Department of Health (MDH) HIV/AIDS Surveillance System. In Minnesota, laboratory-confirmed infections of human immunodeficiency virus (HIV) are monitored by the MDH through this active and passive surveillance system. State law (Minnesota Rule 4605.7040) requires both physicians and laboratories to report all cases of HIV infection (HIV or AIDS) directly to the MDH (passive surveillance). Additionally, regular contact is maintained with several clinical sites to ensure completeness of reporting (active surveillance).

Data Limitations

The prevalence estimate is calculated by totaling the number of HIV and AIDS cases diagnosed through December 31, 2003 who are not known to be deceased and whose most recently reported state of residence was Minnesota. It bears noting that persons who are HIV-infected but not yet tested are not included in this prevalence estimate. Migration (known HIV-infected persons moving in or out of the state) also affects the estimate. Refer to the *HIV/AIDS Prevalence & Mortality Technical Notes* for a more detailed description of data inclusions and exclusions.

Factors that impact the completeness and accuracy of the available surveillance data on HIV/AIDS include the level of screening and compliance with case reporting. Thus, any changes in numbers of infections may be due to one of these factors, or due to actual changes in HIV/AIDS occurrence.

PERSONS LIVING WITH HIV/AIDS IN THE UNITED STATES

The Centers for Disease Control & Prevention (CDC) estimates that there are 800,000 to 900,000 people currently living with HIV/AIDS in the United States. The number of people specifically living with AIDS in the United States has been increasing in recent years: from approximately 290,400 in 1998 to approximately 384,900 in 2002.¹

PERSONS LIVING WITH HIV/AIDS IN MINNESOTA

Overview of HIV/AIDS in Minnesota, 1990-2003

The number of persons assumed to be living with HIV/AIDS in Minnesota has been steadily increasing over time. As of December 31, 2003, 4,895 persons known to be living with HIV/AIDS resided in Minnesota, a 6.5% increase from 2002. While the number of HIV (non-AIDS) diagnoses has remained steady since the mid-1990s at just under 200 cases per year, both the number of newly diagnosed AIDS cases and the number of deaths among AIDS cases have been declining since 1996. The decreases are primarily due to the success of new treatments introduced in 1995 (protease inhibitors) and 1996 (highly active antiretroviral therapy or HAART). These treatments do not cure, but can delay progression to AIDS among persons with HIV (non-AIDS) infection and improve survival among those with AIDS. Thus, the declines slowed during the late 1990s and the numbers have been relatively stable the past few years.

Living HIV/AIDS Cases, 2003

Among the estimated 4,895 prevalent cases in Minnesota, 2,880 are diagnosed with HIV (non-AIDS) and 2,015 are diagnosed with AIDS. The majority (88%) of prevalent cases reside in the seven-county metropolitan area surrounding the Twin Cities of Minneapolis and St. Paul (Hennepin, Ramsey, Anoka, Dakota, Scott, and Washington counties). Although HIV infection is more common in communities with higher population densities and greater poverty, there are people living with HIV or AIDS in over 80% of counties in Minnesota.

¹ Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report* 2002:14.

Gender & Race/Ethnicity

Seventy-nine percent (79%) of prevalent HIV/AIDS cases are males. Broken down by race/ethnicity, 64% of male cases are White, 20% African American, 7% Hispanic, 5% African-born, 2% American Indian, and 1% Asian/Pacific Islander. In total, 36% of males living with HIV/AIDS are non-White whereas only 12% of the general male population is Non-White. Among female cases, the distribution is even more skewed toward women of color: 31% White, 35% African American, 22% African-born, 6% Hispanic, 4% American Indian, and 2% Asian/Pacific Islander. Thus, 69% of prevalent female HIV/AIDS cases are non-White whereas only 11% of the general female population in Minnesota is non-White.

Please note that race is not considered a biological reason for disparities related to HIV/AIDS experienced by persons of color. Race, however, can be considered a marker for other personal and social characteristics that put a person at greater risk for HIV exposure. These characteristics may include, but are not limited to, lower socioeconomic status, less education, and less access to health care.

Age

Seventy-eight percent (78%) of persons living with HIV/AIDS in 2003 are currently 35 years of age or older. Broken down into five-year age groups, 40-44 year olds make up the largest group (24% of cases), followed by 35-39 year olds (21%) and 45-49 year olds (16%).

Mode of Exposure

The proportions of living cases attributable to particular modes of exposure differ among gender and race groups. While 80% of White males reported male-to-male sex (MSM or MSM/IDU) as a risk factor, only 46% of non-White males reported this mode of exposure. The difference in proportions is partly explained by the relatively large number of non-White males with unspecified risk, particularly among African-born and Asian men. It is hypothesized that due, in part, to social stigma many of the cases with unspecified risk were unclassified MSM cases. This may not hold as true for African-

born cases given that heterosexual contact and contaminated medical equipment have been established modes of HIV exposure in their countries of origin. The percent of male cases that identified IDU, MSM/IDU, or heterosexual contact with an injecting drug user as a risk factor was particularly high for American Indians (28%), African Americans (27%) and Hispanics (22%). The percentages among White, Asian, and African-born males were 11%, 4%, and 2%, respectively. Similar to the MSM category, IDU may be underreported due to social stigma.

Across all race/ethnicity groups, females most frequently report heterosexual contact as their mode of HIV exposure. However, IDU was reported as directly or indirectly (via heterosexual contact with a person who injected drugs) involved in a large percentage of female cases among most race/ethnicity groups. The largest percentage of IDU-related cases occurred among American Indians (61%) followed by Whites, African Americans, and Hispanics with 38%, 37%, and 37%, respectively. One case among African-born females was related to IDU and no cases among Asian females. African-born females living with HIV/AIDS had the largest percentage of cases with unspecified risk: 79% compared to approximately 20% among the other female race/ethnicity groups. The number of prevalent HIV/AIDS cases among Asian females was too small (n = 22) to make generalizations about risk. See the *HIV/AIDS Prevalence & Mortality Technical Notes* for a detailed discussion of mode of exposure categories.

Emerging Trend

Between 1990 and 2003, the number of foreign-born persons living with HIV/AIDS in Minnesota increased substantially, especially among the African-born population. In 1990, 51 foreign-born persons were reported to be living with HIV/AIDS in Minnesota, and by 2002 this number had increased ten-fold to 550 persons. In 2003, the total number of foreign-born persons living with HIV/AIDS was 660, a 20% increase from 2002. This trend illustrates the growing diversity of the infected population in Minnesota and the need for culturally appropriate HIV care services and prevention efforts.

The characteristics of foreign-born persons living with HIV/AIDS in Minnesota differ from U.S.-born, especially in gender. While females account for 17% of cases

among U.S.-born persons, they account for 41% of foreign-born cases. This is especially noticeable among African-born cases, where women account for 51% of those living with HIV/AIDS in Minnesota. Among Asian-born cases, women account for 36% of cases. The gender distribution among cases born in Latin America, the Caribbean and Europe is similar to that of U.S.-born cases.

HIV/AIDS MORTALITY IN MINNESOTA

The number of deaths² among Minnesota AIDS cases decreased between 1995 and 1997 and remained relatively constant between 1997 and 2003. The largest declines in mortality were observed among White males in the mid 1990s. In recent years, the number of deaths among AIDS cases has been comparable between White and non-White males and between White and non-White females. In 2003, a total of 54 deaths were reported among AIDS cases. Of these deaths, ten (10) were among women and 44 among men.

² Includes all deaths, regardless of cause.