

Annual HIV/STD 2021 Data Release Live Webinar

Introduction

Slide 1

Slide 2

OK, we're going to go ahead and get started. Again, my name is Chrissy Jones. It's turned my camera on here, Christine Jones. I am the section manager for the STD/HIV/TB section at the Minnesota Department of Health. Welcome to the annual HIV/STD 2021 data release. Today, our meeting will run from 2:00 until 3:00 o'clock this afternoon. We will be going over our 2021 STD data as well as our 2021 HIV data. And then we'll have some time at the end for questions and answers.

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Some reminders as we're working through this webinar, if you have any questions or comments throughout the presentation, please put them in the chat box and all questions will be answered at the end. The ones that we are not able to get to today will be sent out via electronic communication. Please note that Q&A option is to the left of your settings gear near the top of your screen. You can select the more option on your screen if you want to enable subtitles also. All data that we present will be available on our website after this session.

Slide 4

So before we get started, I just want to take a moment to acknowledge that Minnesota stands on ancestral land of tribal nations. This includes the Dakota, the Ojibway, Ho chunk and other nations. I ask you all to just please take a moment to consider the Treaties that were made by the Tribal nations that entitle non-native people to live and work on traditional native lands. So I'll just give you a minute to look over that land acknowledgement. (pause)

Alright, so now we will move on, and I will turn it over to Khalid Bo-Subait to do our STD annual data.

STD Presentation

Slide 5

Good afternoon, everybody. Thank you, my name is Khalid Bo-Subait. I'm the STD surveillance coordinator and epidemiologist. I'll be walking us through the data release for 2021. Next slide.

Slide 6

So STI's in Minnesota in the year 2021. A total of 33,706 STD cases were reported to the Minnesota Department of Health. This is including 22,578 chlamydia cases, 9,671 gonorrhea cases, 1,457 syphilis cases of all stages and zero chancroid cases. Next slide.

Slide 7

We can see the rate for chlamydia in Minnesota increased by 3% to a rate of 425.7 per 100,000 compared to 413.7 in 2020. The rate of gonorrhea in Minnesota decreased 5% to 182.3 per 100,000 when compared to 192.6 last year. The rate of primary and secondary syphilis increased by 36% in 2021 from 7.8 in 2020 to 10.6 per 100,000 in 2021, next slide.

Slide 8

So interpreting STD surveillance data, so factors that impact the completeness and accuracy of STD data include the level of STD screening by healthcare providers, individual test seeking behavior, sensitivity of diagnostic tests, compliance with case reporting, completeness of case reporting, and timeliness of case reporting. Increases and decreases in STD rates can be due to actual changes in disease occurrence and/or changes in one or more of the above factors. It's important to note that COVID-19 lockdowns likely played a role in the number of cases that are reported or diagnosed in the past year. Next slide.

Slide 9

So now we will take a look into syphilis. Next slide.

Slide 10

Syphilis rates by stage at diagnosis in Minnesota. So the overall syphilis rate is 27.5 per 100,000, an increase from 2020 and a 300% increase from a decade ago. Of concern is the rate of primary and secondary syphilis, which is 10.6 per 100,000, a 36% increase from 2020. Next slide.

Slide 11

The statewide rate for primary and secondary syphilis increased to 10.6 per 100,000 from 7.8 last year. Within the metro, the highest rate of primary and secondary syphilis remains in the city of Minneapolis at 49.7 cases per 100,000 population. The City of Saint Paul has the second highest rate in the metro at 28.4 per. 100,000. Next slide.

Slide 12

Primary and secondary syphilis infections by residence at diagnosis in our state, 2021. The City of Minneapolis had the largest percent of all reported primary secondary syphilis cases with 35%, second to greater Minnesota with 26% of the cases. The Suburban 7 county metro area reported 26% of the cases and the city of Saint Paul reported 14% of the cases. Next slide.

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Primary and secondary syphilis rates by gender in Minnesota. Males have the highest rate of primary and secondary syphilis at 16 cases per 100,000. The rate of primary and secondary syphilis in females is 5.4 per 100,000. Next slide.

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Age-specific primary and secondary syphilis rates by gender. Males have the higher rate of primary and secondary syphilis when compared to females in all age groups. The rate in males is 3 times higher than that of females. 30 to 39 year old males had the highest rate at 44 per

100,000. 25 to 29 year old females had the highest rate of the female population at 19.4 per 100,000. Next slide.

Slide 15

Primary and primary and secondary syphilis cases by race. 42% of all primary secondary cases were reported as white, non-Hispanic Black. Non-Hispanic cases made up 26% of all primary and secondary syphilis cases followed by American Indian cases at 10%, Hispanic cases at 7%, and Asian Pacific Islander cases at 3%. Next slide.

Slide 16

Primary and secondary syphilis rates by race and ethnicity. Large disparities continue to exist in the rates of syphilis when compared to the lowest rate that's reported, which is amongst the white, not Hispanic population. The rates of primary and secondary syphilis are 16.7 times higher in the American Indian population when compared to the lowest reported rate amongst the white, not Hispanic population. The rates of primary and secondary syphilis are 9.9 times higher in the Black African American, not Hispanic, when compared to the white, not Hispanic population. The rates of primary secondary syphilis in the American Indian population are 95.1 per 100,000 compared to 5.7 per 100,000 in the white, not Hispanic population. The rates of primary secondary syphilis in the Black African American non-Hispanic population are 57.7 per 100,000. The rates in the Hispanic population are 16 per 100,000, which is 3.1 times higher than that of the white non-Hispanic population. The rates in the Asian Pacific Islander population are 6.8 per 100,000, which is 1.3 times higher than that of the white, non-Hispanic population. One thing I do wanna highlight with this slide (and this slide will be reproduced for chlamydia and gonorrhea) is that the comparison group of white non-Hispanic is being done as the white non-Hispanic rate is the lowest. So it gives us a value of understanding how disparities are impacting some of these races throughout our state. Next slide.

Slide 17

So this is a topic of interest, which is syphilis among females and congenital syphilis in the state of Minnesota. Next slide.

Slide 18

So female early syphilis cases. In Minnesota, the number of early syphilis cases has increased dramatically over the last 10 years, from 13 cases in 2011 to 253 and 2021. Next slide.

Slide 19

Early syphilis infections in females by residents at diagnosis. In Minnesota 39% of female early syphilis cases were diagnosed in greater Minnesota. 22% of all female early syphilis cases were residents of the suburban 7 county metro area. 24% of the early syphilis cases amongst females were city of Minneapolis residents and 15% were Saint Paul residents. Next slide.

Slide 20

Early syphilis cases in females by race and ethnicity in 2021. There are large disparities in women with syphilis. 26% of all early syphilis cases are found in the American Indian Alaskan Native population and 21% in the Black African American population. Next slide.

Slide 21

Congenital syphilis rates among infants in Minnesota. In Minnesota, the number and rate of congenital syphilis cases among infants has increased in 2021 compared to 2020. Overall, the rate has increased over the past five years from a rate of 3 per 100,000 live births in 2017 to 23.6 per 100,000 live births in 2021. Syphilis may be passed from a pregnant person to the unborn baby through the placenta. The infections can cause miscarriages and stillbirths, and infants born with congenital syphilis can suffer a variety of serious health problems, including deformities, seizures, anemia, and jaundice. The Centers for Disease Control and Prevention reported this past fall that the number of infants born with syphilis has increased more than 200% in the last four years, and last year reached a 20-year high. Next slide.

Slide 22

The next topic of interest is early syphilis amongst men who have sex with men in Minnesota. Next slide.

Slide 23

If you see MSM, that's just the acronym for men who have sex with men. The number of early syphilis cases by gender and MSM status early syphilis includes not only primary and secondary syphilis, but all new syphilis infections acquired within the past year. Of all early syphilis cases, 73% were amongst people whose gender was currently being reported as male. Men who have sex with men account for 61% of all those cases amongst men. Next slide.

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Early syphilis cases amongst MSM by age. The average age of MSM with early syphilis is the age of 38 years. Ages ranged from 16 to 77 years of age. The 30 to 34 year old age group had the highest number of cases at 94. And 39% of all early syphilis cases are amongst MSM in the 25-34 age groups. Next slide.

Slide 25

Early syphilis cases coinfecting with HIV. So 24% of all early syphilis cases were coinfecting with HIV. 50% of all MSM early syphilis cases were coinfecting with HIV. Next slide.

Slide 26

Next, we're going to jump into gonorrhea. Cases of reported gonorrhea saw the greatest decrease of 5% in 2021. There were 10,217 cases reported in 2020 compared to 9,671 in 2021.

Slide 27

The rate of gonorrhea in Minnesota reached an all-time high at 182.3 per 100,000. This was a rate decreased of 5% from 2020. The city of Minneapolis continues to have the highest rates of gonorrhea at 764 per 100,000, followed by the city of Saint Paul at 514 per 100,000, and the suburban area (seven-county metro excluding Minneapolis & St. Paul) at 126 per 100,000, followed by Greater Minnesota with the rate of 97 per 100,000. The seven-county metro suburban area had the highest increase at 37%, followed by the city of Saint Paul with a 29% increase. Next slide.

Slide 28

Gonorrhea rates by gender and Minnesota. The rates of gonorrhea went down in both males and females in 2021. Males continue to have higher rates of gonorrhea than females, but the rates in females is increasing. When we look at it historically, despite seeing a decline last year, males had a high rate of 202 per 100,000, which is a 2% decrease from the 2020 rate of 206 per 100,000. Females had a rate of 163 per 100,000 in 2021, which is a decrease of 9% over the 2020 rate of 179 per 100,000. Next slide.

Slide 29

Gonorrhea rates by age. Most age groups saw a decrease in gonorrhea rates. The highest rate remains in the 20- to 24-year-old age group at 642 per 100,000. The 15- to 19-year-old age group had the largest increase from 388 in 2020 to 397 in 2021, a 2% increase.

Slide 30

Age-specific gonorrhea rates by gender. Females under the age of 25 continue to have the highest rates of gonorrhea when compared to males. Males record the highest rate among age groups older than the age of 25 years. The highest rates of gonorrhea are in females, aged 20 to 24, with the rate of 682 per 100,000.

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There continues to be large disparities in the rates of gonorrhea. The Black African American non-Hispanic population rates are 20.6 times higher when compared to the lowest rate reporter, which is amongst the white non-Hispanic rate. The rate in the Black African American population was 1,370 per 100,000 compared to the rate in the white non-Hispanic population, which was 67 per 100,000. The American Indian population had a rate that was 9.2 times higher at 609 when compared to white non-Hispanic rate. The Asian Pacific Islander population had a rate that was 1.5 times higher at 98 per 100,000. The Hispanic/Latino population, which can be of any race, had a rate that was 3.7 times higher at 249 per 100,000. Next slide.

Slide 32

Next we'll jump into chlamydia. Chlamydia increased 3% in 2021, when compared to 2020, which recorded its first decline in over a decade. This result could be due to a true decrease in the number of cases, but it could also reflect the COVID-19 pandemic and reduced preventative visits. Chlamydia is more likely to be asymptomatic than gonorrhea and syphilis, especially in females. Next slide. Go back a slide, sorry.

Slide 33

All counties in Minnesota were affected by chlamydia. There were at least 2 cases in all counties in 2021. The city of Minneapolis continues to have the highest rates of chlamydia at 1,206 per 100,000 followed by the City of Saint Paul at 894 per 100,000. The suburban area (7-county metro area, excluding Minneapolis and Saint Paul), had a rate of 348 per 100,000, and greater Minnesota had a rate of 306 per 100,000. Next slide.

Slide 34

Chlamydia rates by gender. The rates of chlamydia increased for both males and females in 2020-2021. Females continue to have higher rates of chlamydia than males. Males had a rate of 308 per 100,000, which is an increase of 2% over the 2020 rate of 295 per 100,000. Females had a rate of 541 per 100,000, which is an increase of 2% from the 2020 rate of 529 per 100,000. Next slide.

Slide 35

Age-specific chlamydia rates by gender. The rates of chlamydia are highest amongst females. Females 20 to 24 years of age continue to have the highest rates at 3,101 per 100,000. Males aged 50 plus reported the largest increase of over 50% when compared to 2020. Next slide.

Slide 36

Chlamydia rates by race and ethnicity in Minnesota. There continues to be great disparities in chlamydia. The Black African American non-Hispanic population has rates that are 10.3 times higher than that of the white non-Hispanic rate which again for chlamydia is similar to syphilis and gonorrhea, which were reporting the lowest rates. The rate in the Black African American, non-Hispanic population was 2024 per 100,000 compared to the rate in the white non-Hispanic population at 196 per 100,000. The American Indian population had a rate that was 4.9 times higher at 970 per 100,000. The Asian Pacific Islander population had a rate that was 1.9 times higher at 382 per 100,000 and the Hispanic population, which can be of any race, had a rate that was 4.6 times higher. Next slide.

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Chlamydia and gonorrhea amongst adolescents and young adults aged 15 to 24 next slide.

Slide 38

Chlamydia continues to disproportionately impact youth and young adults. 15- to 24-year-olds make up only about 14% of the population, but account for 60% of all chlamydia cases reported in 2021. Next slide.

Slide 39

Similarly, gonorrhea is also proportionately impacting the youth and adults in Minnesota. Again, 15- to 24-year-olds only make up 14% of the population, but account for 37% of all gonorrhea cases reported in 2021. Next slide.

Slide 40

Chlamydia and gonorrhea rates among adolescents and young adults by gender in Minnesota. The rates of clinic gonorrhea are higher in females compared to males in the 15- to 24-year-old age group. The rates for chlamydia and females are 2,730 per 100,000 compared to males at 1,035 per 100,000 population. The rates of gonorrhea in females is 573 per 100,000 compared to 427 per 100,000 in males. Next slide.

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This slide is a summary of characteristics of adolescents and young adults diagnosed with chlamydia or gonorrhea in 2021. In adolescence and young adults, the majority of chlamydia

gonorrhea cases are reported are females at 68%. A little over 1/3 (36%) are white, not Hispanic, followed by about 1/3 that are reported as Black, non-Hispanic. 19% were unknown or more than one race. Adolescents and young adults accounted for 60% of all chlamydia cases and 37% of all gonorrhea cases reported in 2021 in Minnesota. Next slide.

Slide 42

Summary of STD trends in Minnesota from 2011 to 2021. From 2011-2021, the chlamydia rate has increased by 34%, the rate of gonorrhea has increased by 324%, and syphilis has increased by 305%. Minnesota has seen a resurgence of syphilis over the past decade with men who have sex with men and those co-infected with HIV being especially impacted. However, the number of females impacted is near record high for the last decade. People of color continue to be disproportionately affected by all STDs in Minnesota, and echoed nationwide. Disparities in the rates of STDs are not explained by differences in sexual behavior, but are due to differences in health insurance coverage, employment status, and access to healthcare with preventative screening and treatment services. Next slide.

Slide 43

I just wanna include this slide this year as well, which is updates to our STD reporting and current follow up. A new clinician gonorrhea report is available on the MDH website. This is to accommodate changes in the STD treatment guidelines and to highlight DGI reporting. The case report form can be filled out or mailed or faxed to MDH at 651-201-4040. More information may be requested on gonorrhea cases for the enhanced gonorrhea surveillance activities, which is a part of a CDC Peach grant. All cases co-infected with early syphilis will continue to be assigned to MDH partner services for follow up. All STD cases continue to have the potential of being contacted by MDH for additional follow up as well. That concludes the STD portion of this data release, and I will transition over to my colleague.

HIV Presentation

Slide 44

Good afternoon. My name is Nathan Blumenfeld. I'm the HIV surveillance operations epidemiologist, and I will be walking you through highlights from our surveillance report for 2021. Next slide please.

Slide 45

So, first, we need to address the impact of COVID-19 on HIV diagnosis. The COVID-19 pandemic in the United States led to disruptions in HIV testing services and access to clinical services throughout 2020. This disruption resulted in a steep single year decline in HIV diagnoses. The number of HIV diagnoses in the United States in 2020 was 17% lower than in 2019. This decrease is predominantly attributed to declines in testing caused by less frequent visits to health centers, reduced outreach services, and shifting of public health staff to COVID-19 response. Strategies implemented by state and local health departments for HIV related testing and care services such as self-testing and telehealth did not make up for declines and laboratory-based HIV testing. Given these disruptions, HIV was likely under-diagnosed in 2020

and data for 2020 should be interpreted with caution. Under-reporting of laboratory test results to state and local HIV surveillance programs was not a major contributor to declines in diagnosis, as all jurisdictions reported to CDC all laboratory results received. Since the COVID-19 pandemic is still ongoing, more time and data are needed to accurately assess COVID-19's effect on HIV in the United States. Assessments of trends in HIV diagnoses that include the year 2020 are discouraged. Next slide please.

Slide 46

And next slide please.

Slide 47

So. In this report, the term new HIV diagnosis refers to Minnesota residents living with HIV who were diagnosed in a particular calendar year and reported to MDH. This includes people whose first diagnosis of HIV infection is AIDS (AIDS at first diagnosis). HIV diagnosis data are displayed by earliest known date of HIV diagnosis. In 2021, there were 298 newly diagnosed cases, compared to 230 cases in 2020. 2020 was an outlier year, however, with a 16% decrease in HIV diagnoses from the previous year likely attributable to the same factors driving the national decrease discussed on the last slide. 298 cases in 2021, while a 30% increase over 2020, is an 8% increase from 2019, and is average compared to the number of diagnoses per year in the prior decade, excluding 2020. More time and data will be required to determine whether this is a true increase in HIV infection rates or if part of the increase is due to a rebound in diagnoses after disruptions in 2020. Next slide please.

Slide 48

Historically, about 80% of new HIV infections diagnosed in Minnesota have occurred in Minneapolis, Saint Paul, and the surrounding 7-county metropolitan area. In 2021, of 298 total HIV diagnoses, 74% of the cases were in the 7-county Twin Cities metro region, with 31% in Minneapolis, 11% in Saint Paul and 32% in the remaining suburban area (excluding Minneapolis and Saint Paul). In Greater Minnesota there were 76 newly diagnosed HIV cases across 39 counties. Next slide, please.

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Comparing the racial and ethnic distribution of new HIV diagnosis on the left to the general population of Minnesota on the right, it is apparent that disparities continue to exist. Non-Hispanic, African American, and Black African-born Minnesotans jointly make up about 5% of the population in Minnesota, yet accounted for 42% of the newly diagnosed cases of HIV in 2021. Similarly, Hispanic people of any race account for approximately 5% of the population, but account for 14% of the newly diagnosed cases. Next slide please.

Slide 50

Each year we calculate the rate of diagnosis for each racial and ethnic group represented in the surveillance system to assess the impact of HIV within each community. The rate takes into account the size of the population of each group. Non-Hispanic Black communities had the highest rate of diagnoses in 2021 with 36.5 HIV diagnosis per 100,000 population among Black African-born people and 53.8 HIV diagnoses per 100,000 among Black, not African born people.

For African Americans who are not African born, this represents a rate that is 22 times the rate in the white non-Hispanic population in Minnesota. The rate among the African-born population is 15 times that of the white non-Hispanic population. Hispanic people of any race have the next highest rate of newly diagnosed HIV cases in Minnesota at 17.2 per 100,000 people; this is a rate 7 times that of white, non-Hispanic people. American Indians have a rate of people newly diagnosed with HIV of 18 per 100,000 people, 7.5 times the rate of white non-Hispanic people. Next slide please.

Slide 51

There are differences in the racial and ethnic distribution by sex assigned at birth. Left to right are data for people assigned male and female at birth respectively. On the left among 234 people assigned the sex of male at birth, 37% of the 2021 cases diagnosed in Minnesota are non-Hispanic white (seen in dark blue). Non-Hispanic Black, non-African born (in light green) and Black African-born males (light blue) made up 38% of cases and Hispanic males of any race accounted for 18% of cases. On the right, among the 64 people assigned the sex of female at birth, the disparities of new HIV diagnosis are even more apparent among people of color. They represent 74% of new HIV cases assigned female at birth versus 63% of new HIV cases assigned male at birth. Greater than half of female infections, or 55% combined, are Black African-born and non-African-born. Next slide please.

Slide 52

Here we look at cases and rates of the 298 new HIV infections by sex assigned at birth and reported sexual behavior. By sex assigned at birth, the number of cases among people assigned male at birth have remained stable, accounting for 234 of 298 new HIV cases. The 64 cases among people assigned female at birth, while an increase from the 37 diagnosed in 2020 still represents a decrease from the 76 diagnoses in 2019. The reason for this decrease is currently unknown. As a result, people assigned male at birth represent 79% of all new HIV diagnosis, which is an increase from previous years. Looking further at data by risk behavior, men who have sex with men have the highest rate of HIV diagnosis. In 2021, the estimated rate of HIV diagnosis among MSM was 137.9 per 100,000 population. This is nearly 38 times higher than the rate among non-MSM men. It's important to note that MSM contains cases from all racial and ethnic categories and therefore it cannot be directly compared to the rates on the previous slide. For more information on how this rate was estimated, see the HIV surveillance technical notes, which are available on our website. Next slide please.

Slide 53

This slide shows the number of people living with HIV and AIDS by gender identity. In 2021, there were 12 transgender HIV cases diagnosed in Minnesota (11 trans women and one other transgender identity). This represents 4% of new cases reported in the state. Next slide please.

Slide 54

In 2021, there were 100 cases diagnosed under the age of 30, accounting for 34% of all cases. 87 (85%) of these were in people assigned to the male sex at birth. Age groups 20 to 24, and 30 to 34 had the largest number of new cases in 2021. Next slide, please.

Slide 55

This slide depicts risk for all people diagnosed with HIV in Minnesota during the past decade. In 2021, mode of exposure was unknown or undisclosed in a plurality or 48% of cases. Of cases where mode of transmission was reported, men having sex with men was the most common, accounting for 42% of all diagnoses, but over 80% of diagnoses with known modes of transmission. The number of cases among people who inject drugs (IDU only) was 20 cases in 2021, down from 2019. Yet an increase from 2018 and 2020. However, Minnesota has declared an ongoing outbreak among people who inject drugs in Saint Louis County, with cases dating back to 2019. Hennepin and Ramsey counties are also experiencing an ongoing outbreak among people who inject drugs, with some cases dating back to 2018. More details on these outbreaks later in this slide presentation. Next slide please. Thank you.

Slide 56

This slide describes HIV diagnosis by global region of birth among foreign born people. In general, the number of new HIV infections diagnosed among foreign-born people in Minnesota has steadily increased from 20 cases in 1990 to an average of 83 cases over the last decade. This increase has been largely driven by the increase of cases among African-born people, as well as people from Mexico, Central and South America, and the Caribbean. In 2021 there were 71 cases of newly reported HIV among foreign-born people. This is about one out of four of all new cases, or 24%. The majority of foreign-born cases in 2021 were from Africa, followed by Latin America and the Caribbean. Next slide, please.

Slide 57

Late testers are defined as anyone with an AIDS diagnosis within one year of their initial HIV diagnosis. They represent missed opportunities for early intervention. In 2020, 21.7% of new cases were testers. This proportion of cases has remained relatively similar over the past ten years, ranging between 22 and 34%. Most late testers, about 85%, are diagnosed with AIDS at the same time they are initially diagnosed with HIV infection. As with other characteristics of the HIV epidemic in Minnesota, the proportion of late testers varies by demographic characteristics. For 2021, 21.1% of new HIV cases were “late testers” to date, which represents only a partial follow-up year through April 2022. Please note that cases diagnosed in 2021 may not encompass all cases diagnosed since a full year of observation is required to capture progress to AIDS within a year (which would end later this year in December 2022). Next slide please.

Slide 58

The ability to interrupt the transmission of HIV from mother to child via antiretroviral therapy and appropriate prenatal care is an important accomplishment in the history of the HIV AIDS epidemic. Without antiretroviral therapy, newborn HIV infection rates range from 25 to 30%, but decrease to 1 to 2% with appropriate medical intervention. The rate of transmission has decreased from 15% between 1994 and 1996 to 0% in the past three years from 2019 to 2021. The last transmission was in 2017. For the past decade, the number of births to pregnant parents living with HIV has ranged between 42 and 69 births. For 2021, there was an increase.

to 60 births to pregnant parents living with HIV with no perinatal HIV cases born to an HIV positive pregnant person in Minnesota in 2021. Next slide please. Thank you.

Slide 59

Next slide please

Slide 60

As of December 31st, 2021, there were estimated to be 9,697 people alive and living with HIV or AIDS in Minnesota. This number included 5,476 or 56% living with an HIV infection that had not progressed to an AIDS diagnosis and 4,221 or 44% living with AIDS. This number also included 2,644 people who are first reported with HIV or AIDS elsewhere and now live in Minnesota, and excludes 1,662 persons first reported with HIV or AIDS in Minnesota, who now live out of state. Next slide please.

Slide 61

One particular population of interest in Minnesota that sets us apart from other states is our larger foreign born HIV positive population. Between 1990 and 2021, the number of foreign-born people living with HIV or AIDS in Minnesota increased substantially, especially among the African-born population. In 1990, 50 foreign-born people were reported to be living with HIV/AIDS in Minnesota and by 2007, this number had increased to 1,126 people. In 2021, the total number of foreign-born people living with HIV/AIDS in Minnesota was 2,553, a 5% increase from 2020. The majority of these people immigrated to the United States from Africa, and Latin America. This trend illustrates the growing diversity of the HIV-positive populations in Minnesota and the need for culturally appropriate HIV care and prevention efforts. Next slide please.

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And next slide please.

Slide 63

Minnesota has seen an increase of HIV among certain populations in Hennepin and Ramsey counties. An outbreak was declared in Hennepin and Ramsey counties among people who inject drugs in 2020, with cases dating back to December 2018. Minnesota's outbreak-associated cases have risk factors consistent with the national outbreaks. People at high risk in the current outbreaks include: people who use injection drugs or share needles/works, people experiencing homelessness or unstable housing, people who exchange sex for income and other items they need. For more information, please see our updated HIV statistics website described at the end of the presentation. Next slide please.

Slide 64

Minnesota has seen an increase of HIV in the Duluth area (30 mile radius). Duluth area declared an outbreak in 2021 with cases dating back to 2019. The Duluth area outbreak includes all newly diagnosed HIV cases and linked cases within the region. Typically, there are one to five cases of HIV per year in Saint Louis County. Beginning in the fall of 2019, there was a significant increase of newly diagnosed HIV cases in the area. People at high risk and outbreaks include

people who use injection drugs or share needles or works, people experiencing homelessness or unstable housing, people who exchange sex for income and other items they need, and men who have sex with men. For more information, please see our updated HIV statistics website described at the end of the presentation. That next slide please.

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In addition to newly diagnosed HIV case counts by county, we update our statistics web page to include information on outbreak data. Please visit the Minnesota Department of Health HIV pages at www.health.state.mn for additional details. While you're here, you can subscribe to our listserv to receive HIV and STD prevention updates to your email. Next slide please.

Slide 66

Thank you very much and I believe now we will turn it over to questions.

Questions & Answers

Thank you so much, presenters. We'll move on to the next portion of our session here, which is Q&A. As a reminder, if any anyone in the audience has a question or a comment you'd like to see answered, please go up to the top of your screen and there should be a Q & A little icon you can click on and type in a question or a comment and we will try our best to get to it today. Otherwise, we will post a document on our website with the answers to the questions that we don't get to. Just one moment here while we start off with our first question.

Question 1: What proportion of syphilis cases among men where among MSM?

I can start just answering the few that I see that are STD-related question. So, the first thing I see is what proportion of syphilis cases among men were among MSM. And I believe, for some reason I was thinking that was the HIV case that we were looking at... that will be a question that we will... oh it's right here. Sixty-one percent of all early syphilis cases were amongst men who have sex with men. So I think that answers that question. And I will double check that, I'm just looking at my slides to see if I can, if I can derive the answer these questions from my slides. And then we will also answer this on the document that will put on the website next week. So loop back there as well.

Question 2: Are there rates displayed crude? Or have there been any adjustments done?

These are just the crude rates that are gonna be based off of the populations that were reported from the 2010 census. We will be updating to the 2020 Census but the Census Bureau has yet to highlight the subpopulations that we use to compute a lot of our rates amongst different races and ethnicities and counties, and stuff like that. So we're hoping to make that tradition next year. So yeah, so rates are crude. I hope that answers that question.

Question 3: How do you explain the low cases of gonorrhea? Is this a decrease in real and attributable, due to behavioral change, or is it because less people may have been tested due to COVID-19?

That is a complicated answer. Unfortunately at MDH we don't get negative test results. So we aren't able to look at how testing is being impacted by COVID-19, but what we can see is just

the number of cases that are gonna be reported. We did in 2021 add a question to our gonorrhea case report form that asks a question with regards to why the patient is being screened as time goes on and that question gets more and more complete. We might get a better picture of what reasons folks are getting screened, whether it's due to signs or symptoms or whether it's due to annual screening. But to answer your question more specifically, I don't believe at this time that it's due to actual a decrease in, like a natural decrease in disease incidence in our state. I think that we're seeing is possibly an adoption of telehealth and things of that nature. I do, I also wanted to highlight the CDC also highlighted that they saw a decrease in 2020 due to COVID due to a decline in screening for chlamydia and gonorrhea. CDC believes that similar to what I had been saying last year and this year, that with gonorrhea that we saw a decline- or sorry- with chlamydia we saw a decline, just due to the nature of it tending to be more asymptomatic especially amongst females, which is where we get most of our cases for our total counts for the year. Gonorrhea though tends to not be as asymptomatic so it is interesting that it went down. I think this year went down. I don't know again, it's gonna take a couple of years to see the trends over time and how COVID impacted this. Last year was unusual because despite seeing a decrease in chlamydia and syphilis, we saw a 27% increase in gonorrhea, which is unusual because chlamydia and gonorrhea screen at the same time and chlamydia obviously has a higher incidence and rate than gonorrhea. So I was led to believe that was just due to it being more symptomatic. So, folks would go in because they were exhibiting symptoms. And so I wonder if this year we just saw a natural decline. But the decline, keep in mind, was a decline compared to last year and last year was a 27% increase. So I still think when we look at things historically over a trend, things are still trending upwards. It's just that this year was a little bit of an unusual thing because we're still, like I said, trying to understand how COVID is going to be impacting people, sexual behavior, people's screenings and stuff like that and how they how they reach their preventative healthcare. Thanks, Khalid.

Back to Question 2: I was just gonna jump in since you were mentioning a response about the rates and if they were crude or adjusted. I see one of our HIV epis Cheryl wanted to make a comment about that with our HIV data. Yes hi, for the HIV data, we also use the crude rates, which is just using the 2010 population from the census. And again, once 2020 rates/populations are out we will be using that. Great. Thank you so much. Cheryl,

Question 4: Could you clarify your source for MSM population estimates?

I'm seeing another question in here about our sources for MSM population estimates and I believe another one of our HIV epis wanted to respond to that question. Yes, hello, everyone. Thank you. There's a question about the source that we've used for our MSM estimates. And so we can clarify that when we do reach out to participants via electronic communication afterwards. But just in summary, it was a partnership done with Emory University in the Center for Disease Control that model data from the American Community Survey, the National Health and Nutritional Examination Survey, as well as census data to come up with MSM estimates by state. And this was done in 2017. Unfortunately, that's the most recent data that we have for MSM estimates for the state of Minnesota. And unfortunately, it's not broken down by race and so that's the data that we have to use at this point. But again, we can send that source out afterwards to the participants. Great, thank you so much.

Question 5: Is there an effort to understand or disaggregate the large percentage of the population that identifies as more than one race? It's a large number of people and it's frustrating that it's lumped in with "unknown".

I see a question here about an attempt to understand the other races category. Khalid, were you going to take that one? Sure! That is a great question that I think is going to be a great time to ask that question. As reporting behaviors and stuff like that changes, we create that group because we do ask for race, like race can be reported up to three times and so it's difficult to categorize an individual who would, for example, report as race one would be Black and non-Hispanic, race two would be, American Indian or Alaskan Native. So, we see trends like that being reported. So, I think that's one of the things that make it a little bit challenging. I would say, if folks are interested in seeing things broken down more specifically, we do have our data request form on our STD website and so if folks are interested in seeing things broken down in a specific way, don't hesitate to reach out and let us know. I do know historically we do try to replicate what the CDC does and how they report race. So that might have been one of the reasons why we chose to break stuff down that way. I know that's why/how the way Hispanic is done. But yeah, I hope that answers that question. Thanks so much, Khalid. And Cheryl, did you want to add anything for that? Yeah, I wanted to add for HIV we have looked at the multi-race variable and we do have like for American Indians, we have any race, and we have up to five race categories in our database. So we do have code that can look for any race and look at that. Especially it's been noted across the United States of low counts for American Indian, Alaskan Native race of people living with HIV, and so we have looked at it and we will be looking for other racial categories. For HIV specifically in Minnesota, we do separate out African-born Black as well as non-African-born Black racial categories. Whereas other state's jurisdictions across the nation may not do that for HIV. And so that we do look for that due to our large population. Thanks. Thanks so much, Cheryl.

Question 6: Does MDH have a surveillance program in place for STIs? Or the reports presented were from control programs only?

I can take another question that we got regarding if MDH have a surveillance program in place for STI's or if the reports presented are from a control programs only. I think what you're asking is if we've got a surveillance program in place for STDs/STIs, and so yes we do. In the state of Minnesota, chlamydia, gonorrhea, and syphilis, as well as chancroid are all reportable diseases to MDH within one business day. And so we get all positive cases reported in our state of those get reported to MDH and so we are doing active surveillance on those, those four STDs. We haven't had a chancroid case though in like a decade. So primarily it includes gonorrhea, chlamydia, and syphilis which would be highlighted today. Great, thanks so much Khalid.

Question 7: How do you all believe the ongoing COVID pandemic impacted testing rates?

It looks like we've got a question about COVID impacting. rates. Does somebody want to take that? Yes, this is Cheryl Barber, I can answer that. We did have a slide for HIV specifically noting that and CDC- the HIV division- did come out with their report in May noting that 2020 HIV data should be viewed with caution due to lower HIV testing, people not able to see providers during this time period, and also you can look at that slide for further information. We'll be posting

more to answer that question. And also even in 2021 and 2022, we'll still be looking at the data over several years to look at the effects. Great. Thank you so much. Cheryl.

Question 8: Does MDH have data regarding which states persons known living with HIV came from (as reported by Wisconsin health department)?

I'm seeing a question here asking about if MDH has data regarding which states people known living with HIV came from. Nathan, did you want to take that one? Sure, so yes, we do have data regarding which states people living with HIV came from. So we do work consistently with other states, as well as with CDC to identify which states people were originally diagnosed in, as well as other states that they may have come from. So yes, we do, we do have that data. Wonderful, thanks so much.

Question 9: With the syphilis numbers, is MDH close to declaring a syphilis outbreak?

I'm seeing a couple other questions regarding STI/STD data, Khalid do you wanna take those? Took me a while to get to my mute button. So, the first question that I see with the syphilis numbers, is MDH close to declaring a syphilis outbreak? So, to answer this question, we've got two ongoing scenarios in our state. So we have had an ongoing outbreak in the Duluth metro area, the 30 mile metro area around Duluth. Those numbers get updated on our website weekly to how the new cases that we're seeing in that area. We also have another instance of an increased incidence in the Beltrami Cass County. This was a downgrade from an outbreak that we did in early February of 2021. Where we're just seeing an increased incidence when we come look at Beltrami & Cass County compared to counties that are of similar population in the area. And so with that, we are still doing all of our same prevention activities and all of our same surveillance activities. We just change the definition. And then to answer your question with regards to declaring an outbreak, I have a monthly outbreak statewide outbreak analysis that allows me to look at historical trends compared to current trends in Minnesota, looking at counties around our state. Now, when we see things that trigger alert levels and stuff like that, we always reach out to local public health as well as our district epis and then do a deeper dive into the epi data to try and understand what we're seeing and what populations are being impacted. Now we're seeing trends in Minnesota that are being echoed nationwide. So nothing that we're seeing in Minnesota is unusual to what we're seeing nationwide. So as we monitor these cases, we're looking for things that are unusual that are unexpected, that we can't explain. So I'm trying to put this in simpler terms, so, we are monitoring cases. It is of obvious concern. We do run because it run this data monthly to see what we're looking at. We do have internal meetings as well, with our epi staff. And then when we have areas concern, we bring in local public health to get their opinion, to identify what their thoughts are on the increased incidence in that area, as well as our district epidemiologists as well. So, like I said, we monitor that ongoing. Look for HANs as well as Partner Link messages when we're seeing increases but like I said, COVID did some weird stuff. So it's really difficult to try and understand why numbers get so wonky sometimes. Excellent, thank you, Khalid.

We've got about 5 minutes left. We'll try to get to as many questions as we can. And as a reminder. we will post the questions and answers on our website next week.

Question 10: Has the statewide HIV care continuum for 2021 also available on MDH's website?

It looks like we've got a question about the care continuum. I think Cheryl was gonna answer that question. Yeah, I can quickly answer a couple questions that I see. The care continuum will not be coming out until later this fall. We have to wait 18 months for death data ascertainment in order to complete the care continuum. So that will be coming out and posted on our website late fall.

Question 11: Following this webinar can you please provide a table or graph that disaggregates HIV incidence and prevalence among MSM by race and ethnicity? Without it, it's difficult to identify disparities among MSM.

And then somebody had a question about table and graphs for MSM by race and ethnicity. Yes, that is in our full slide set that will be posted after the webinar today. Today, we just presented a small snapshot of kind of the full slide set. That's both for HIV and STI's here. Thank you. Thanks so much. Cheryl,

Question 12: For congenital syphilis, which measures is MDH designing to reduce the rate of congenital syphilis vertical transmission?

Let's take one more question. It looks like there's a congenital syphilis question. Yeah, for congenital syphilis, which measures is MDH designing to reduce the rate of congenital syphilis vertical transmission. This is an excellent question and it's been at the heart of a lot of our prevention activities internal and a lot of conversations as well as like I said, with the trends CDC released that they're seeing. This is also of a high priority and concern. Specifically in Minnesota, we introduced a congenital syphilis review board in early 2020, specifically looking to identify missed opportunities and interventions we could possibly introduce into healthcare screenings, as well as healthcare protocols for facilities when they see mothers who are pregnant, whether at first prenatal visit or other opportunities. And then also evaluate like I said, missed opportunities to try to identify, if a mom for example asked for an STD screen and got chlamydia, gonorrhea, but did not get syphilis. So we're looking to, we began this congenital syphilis review board and our goal is to identify some of these missed opportunities and formulate them into a document that we could release to healthcare providers that would be a list of recommendations that MDH would have to help reduce the burden of congenital syphilis in our state. Additionally, we're not naive to the fact that there's a direct correlation with the increase in syphilis cases amongst females and the impact that has on the likelihood of introducing more congenital syphilis cases in our state. So, one of the things that we've been working on here at MDH is we're looking at doing a lot of different prevention activities around our state as well as a media campaign that's going to be distributed around our metro area. Basically highlighting the burden that we're seeing among females, and trying to educate the public, as well healthcare providers, on getting screened and getting treated and highlighting how easy it is to prevent congenital syphilis if folks follow the recommended screening guidelines of getting screen at prenatal visits. And stuff like that, but unfortunately, as STD's and syphilis continue to rise, there's just more opportunities for missed opportunities. So yeah, I hope that answers that question. Thank you so much, Khalid.

And thanks everybody for your wonderful presentations and for folks in the audience for attending and engaging so well. So as a reminder, we will be posting the question and answers on our website sometime next week. We'll be posting the recording of this session next week as

HIV AND STD DATA RELEASE WEBINAR TRANSCRIPT

well. And later on this afternoon, you'll be able to download the more in depth slide decks as well as the data tables that are updated with 2021 data. And then on that same web page, there's a link to request more data, a couple of our presenters mentioned that. As well as sign up for our email alerts if that's not something you already receive. Thank you everyone so much for being present and we're going to close the session now.