Annual HIV/STD 2022 Data Release Live Webinar Transcript

Introduction

Slide 1

Good afternoon, everybody. This is Chrissy Jones. I'm the manager of the STD/HIV/TB section at the Minnesota Department of Health. Welcome and I thank you for joining us for the annual HIV/STD 2022 data release. We're going to wait just about 30 seconds to give people a little bit of time to join us before we get started. In the meantime, I will be going over the agenda and some ground rules, and if you have questions or if you're having any issues at all, please put your message in the chat and it will be monitored. Again, we will get started in about 30 seconds. Thanks.

OK, let's go ahead and get started.

Slide 2

Again, thank you everybody. Welcome again to the annual HIV/STD 2022 data release. Again, my name is Chrissy Jones and I am the section manager for the STD/HIV/TB section at the Minnesota Department of Health. Welcome to the HIV/STD data 2022 Data Release. Today, our meeting will run from 3:00 to 4:00 this afternoon. We will be going over our 2022 STD data as well as our 2022 HIV data, and then we'll have some time at the end for questions and answers.

Slide 3

Some reminders as we're working through this webinar. If you have any questions or comments throughout the presentation. Please use the Q&A button and put them in there 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. And 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 as well.

Slide 4

Before we begin our webinar, we take a moment to acknowledge that Minnesota stands on ancestral land of tribal nations, including the Dakota, Ojibway, Ho, Chunk, and other nations. We'll take a moment to consider the treaties made by the tribal nations that entitle non-native people to live and work on traditional native lands.

The land acknowledgement:

> Every community owes its existence and vitality to generations from around the world who contributed their hopes, dreams, and energy to making the history that led to this moment. Some were brought here against their will, some were drawn to leave their distant homes in hope of a better life, and some have lived on this land for more generations than can be counted. Truth and acknowledgment are critical to building mutual respect and connection across all barriers of heritage and difference.

> We begin this effort to acknowledge what has been buried by honoring the truth. We are standing on the ancestral lands of the Dakota people. We want to acknowledge the Dakota, the Ojibwe, the Ho Chunk, and the other nations of people who also called this place home. We pay respects to their elders past and present. Please take a moment to consider the treaties made by the Tribal nations that entitle non-Native people to live and work on traditional Native lands. Consider the many legacies of violence, displacement, migration, and settlement that bring us together here today. Please join us in uncovering such truths at any and all public events.*
>
> *This is the acknowledgment given in the USDAC Honor Native Land Guide – edited to reflect this space by Shannon Geshick, MTAG, Executive Director Minnesota Indian Affairs Council

I will now turn it over to Khalid to start our STD surveillance report.

STD Presentation

Slide 5

Good afternoon, everyone. My name's Khalid Bo-Subait. I serve as the STD surveillance coordinator and STD epidemiologist over here at MDH, and I'm going to be going over the STD slides. So, yeah, let's get started. Next slide, please.

Slide 6

So, first I'm going to go over some of the introduction. It kind of goes over what surveillance data is and what gets reported to MDH, there's just some boilerplate. But yeah, under Minnesota State law, physicians and laboratories are required to report all lab confirmed cases of chlamydia, gonorrhea, syphilis, and chancroid to MDH within one working day, ideally. MDH does not maintain statistics for other non-reportable STDs such as herpes, HPV, or genital warts. This slide set describes trends in reportable STD in Minnesota by person, place, and time. This analysis does exclude reported cases from federal and private prisons, so that's one important thing to highlight. Next slide, please.

Slide 7

So next I'll talk about like, what STD surveillance data is. It's the systemic collection of data from cases for the purposes of monitoring the frequency and distribution of STDs in a given population. Our surveillance data is used to detect problems, prioritize resources, develop and target interventions, as well as evaluate the effectiveness of some of our interventions that we implement. Next slide, please.

Slide 8

Some things to keep in mind when interpreting STD surveillance data is that there are some factors that can impact the completeness and accuracy of surveillance of STD data: level of STD screening by healthcare providers, individual testing behavior, sensitivity of diagnostic tests, compliance with case reporting, completeness of case reporting, timeliness of case reporting. And all of these factors can increase or decrease STD rates due to actual changes in disease

occurrence or any of the changes in the factors above that I listed. A good example of this is COVID-19 likely played a role in the number of cases that are being reported or diagnosed over the past few years as people may have delayed care and or adopted more telehealth options. Next slide, please.

Slide 9

The surveillance system only includes cases with a positive lab result, so cases diagnosed on symptoms are not counted in our data. Since 2012, we have included cases that have only reported lab level data. No corresponding - sorry, let me start over. Since 2012 we've included lab-only data without like a paper case report form and this has increased the number of unknown variables but as a benefit we obviously are getting more accurate incidence of disease being reported in 2020. The COVID-19 response accelerated the use of laboratory reporting by facilities and again a downside that with increasing lab reporting is an increase in the number of unknown variables unfortunately for some cases. In 2018, to be consistent with CDC, we categorize all white, Hispanic and Black, Hispanic cases as Hispanic. This means that race categories now reflect only white non-Hispanic and black, non-Hispanic. And one more big point to highlight is that surveillance STD data represents cases of infection, not individuals, meaning a person can have multiple infections and the multiple infections will be counted when we're talking about the cases in this report. And caution is warranted when interpreting changes in STD numbers that can seem disproportionately large when given the number of cases is small in a community. Next slide, please.

Slide 10

So now we'll get into the overview of STDs in Minnesota and some of the nitty gritty of the numbers. So next slide please.

Slide 11

In the year 2022, there were 32,072 STD cases reported to MDH in 2022. That's 22,079 chlamydia cases, 8,161 gonorrhea cases, 1,832 syphilis cases of all stages and 0 chancroid cases. Next slide, please.

Slide 12

This is a good slide that kind of just visually will show the incidence of chlamydia, gonorrhea, and primary and secondary syphilis over time. And I'll kind of highlight what we saw last year. So in Minnesota, chlamydia did decline last year 2% to a rate of 416 compared to 425 in 2021. The rate of gonorrhea also decreased 16% last year to a rate of 153.9 compared to 182.3 and 2021 and the rate of primary and secondary syphilis increased 20% from 10.6 and 2021 to 12.7 in 2022. Next slide, please.

Slide 13

So now we'll go into some of the syphilis data. Next slide, please.

Slide 14

And this is another slide that shows incidence over time, and we can see that the overall syphilis rate last year, 2022, was 34.5 per one per 100,000. This represents a 25% increase from 2021 and a 440% increase from a decade ago. Next slide.

Slide 15

The statewide rate of primary and secondary syphilis increased to 12.7 per 100,000 from 10.6. Within the Metro, the highest rate of primary secondary syphilis remains in the city of Minneapolis at 62.7 per 100,000. The City of Saint Paul has the second highest rate and the metro comes in at – Saint Paul has the second highest rate in the metro at 29.5. Excuse me. Suburban came in at 8.3 per 100,000 and Greater Minnesota reported 7 per 100,000 in 2022. Next slide.

Slide 16

Now we'll take a look at where some of these cases are coming from by residence at time of diagnosis for primary and secondary syphilis, and we can see that the city of Minneapolis had the largest percent of all reported primary secondary cases with 35%. Second is suburban Minnesota with 27% and third largest was in Greater Minnesota with 25%. Saint Paul reported 12% last year. Next slide, please.

Slide 17

This is the slide that takes a look at primary and secondary syphilis rates by gender in Minnesota and we can see males have the highest rates of primary and secondary syphilis at 18.3 per 100,000 last year and the rate of primary and secondary syphilis in females was 7.3 per 100,000 last year. And we can see that over time we've been seeing increases - and we'll get into the increases we we've been experiencing in females in a few of my slides later on. Next slide, please.

Slide 18

So now we'll take a look at age specific primary and secondary syphilis rates by gender in Minnesota, and we can see that males have higher rates of primary and secondary syphilis than females in all age groups. The rate in males is 2.5 times higher than females. 30- to 39-year-old males had the highest rate at 52.6 for 100,000 and 30- to 39-year-old females had the highest rate amongst the female population at 22.7 per 100,000. Next slide, please.

Slide 19

Now we can take a look at primary and secondary syphilis cases by race in Minnesota in 2022 and we can see that we had 676 primary and secondary syphilis cases last year. 44% of them were reported in the white, non-Hispanic population. Black non-Hispanic cases made up 29% followed by American Indian Alaska Natives at 9% and Hispanic cases reported 13% of cases, with Asian American Pacific Islanders reporting 3% of cases. Next slide, please.

Slide 20

This is the slide that highlights and illustrates the rates by race and ethnicity in Minnesota that we've seen over time and I'll discuss what we saw in 2022. So there continues to be large disparities in the rates of primary and secondary syphilis when compared to the white, non-

Hispanic population, meaning white, non-Hispanic population is the population that reports the lowest rate, so the least impacted. But we have seen increase in that community as well, but we're gonna be using the lowest rate to compare against. So the rates of primary secondary syphilis are 14.7 times higher in the American Indian/ Alaskan Native populations when compared to the white, not Hispanic population. Black African American, non Hispanic - the rates are 11 times higher when compared to the white, non-Hispanic rate. When we look at the rate in the American Indians we can see that it's 89.1 per 100,000 compared to 6.1 in the white, non-Hispanic population. Rates of primary and secondary syphilis in the Black, non-Hispanic population are 66.9 per 100,000 and the rates in the Hispanic population are 33.6 per 100,000, which is 5.5 times higher than the white, non-Hispanic. The rates in the Asian Pacific Islander population are 8.2 which is 1.3 times higher than the white, non-Hispanic population.

Slide 21

Next, we'll take a look at a topic of interest, which is syphilis cases in females and congenital syphilis. Next slide.

Slide 22

I think this is an important slide which really can just show the significant increase in cases we've been seeing amongst early syphilis cases in female. I want highlight early syphilis includes primary, secondary, and early nonprimary non secondary. So the first 3 stages of syphilis make up early syphilis. So we can see that last year we had 345 and 10 years ago we had 18 so we can see that there's been a pretty dramatic increase over the past couple of years of cases impacting females. Next slide.

Slide 23

Early syphilis infections in females by residents at time of diagnosis in Minnesota. We can see that there were 345. 29% came from Greater Minnesota, 25% came from the seven County metro area of the suburbs excluding Minneapolis, Saint Paul, and 32% came from Minneapolis while 14% came from Saint Paul. Next slide, please.

Slide 24

Again, here we see large disparities and the female population with early syphilis. 24% of all early syphilis cases can be found in the American Indian Alaskan Native population, 22% in the Black, African American, non-Hispanic population and 38% in the white, non-Hispanic population. Next slide, please.

Slide 25

This is the interesting slide that shows the number of congenital syphilis cases that we've been seeing in the state of Minnesota over the last couple of years. So we can see that the number and rate of congenital syphilis cases among infants has increased in 2022 compared to 2021. Overall, the rate has increased over the past five years from a rate of 15.2 per 100,000 in 2018 to 31.7 per 100,000 in 2022. 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 that was concerned from a variety of serious health problems including deformities, seizures, anemia, and jaundice. The Center for Disease Control reported last year

that the number of infants born with syphilis has increased more than 200% over the last four years and last year reached a 20 year high. And one thing just before I go to the next slide to highlight is that the trends that we've been seeing in our state when it comes to increases of early syphilis amongst females or people who can become pregnant as well as congenital syphilis is being echoed with what the CDC has been reporting nationwide. So what we're seeing in our state is not unique to what's being seen nationwide. Next slide, please.

Slide 26

Topic of interest: early syphilis amongst men who have sex with men in Minnesota. Men who sex with men make up a majority of the early syphilis cases that we have. Next slide.

Slide 27

So we can see that the number of early syphilis cases by gender and MSM sets in Minnesota from 2012 to 2020. Yeah, as I mentioned, early syphilis includes the first 3 stages of syphilis. Of all early syphilis cases, 72% of cases last year were reported amongst those who reported their current gender as male. Men who have sex with men accounted for 59% of all early syphilis cases amongst men. Next slide, please.

Slide 28

Here we can see early syphilis cases by MSM by age in Minnesota, and we can see that there were 511 early cases amongst MSM reporting folks. The average age was 38, a range of 16 to 77. The 30- to 34-year-old age group had the highest number of cases at 99 reported and 49% of all early syphilis cases are amongst folks that report MSM in the age groups 25 to 39 years of age. Excuse me. Next slide, please.

Slide 29

This is an interesting slide that highlights the changes over time of early syphilis cases amongst folks who report as MSM as well as what we're seeing statewide amongst all folks. So 23% of cases in 2022 were coinfected with HIV of all early syphilis cases and 47% of all MSM early syphilis cases were coinfected with HIV. And as you can see, one positive sign is overall we are seeing a downward trend which is a positive thing to be seeing. Next slide, please.

Slide 30

Next, we'll be discussing gonorrhea. Cases of reported gonorrhea saw the greatest decrease of 16% - 9,671 in 2021 compared to 8,161 in 2022. Next slide, please.

Slide 31

This is kind of a heat map where we can kind of see where some of the areas in our state are being impacted the most by rate and we can see that the rate of gonorrhea in Minnesota was 154 per 100,000. This represents a 16% decrease from 2021. The City of Minneapolis continues to have the highest rates of gonorrhea at 693 per 100,000, followed by Saint Paul at 442 per 100,000. The seven-county suburban metro area, excluding Minneapolis and Saint Paul, came in at 111. And Greater Minnesota reported 72 per 100,000. One thing to note is the rates of gonorrhea decreased in all areas across our state when we look at it by those regions that I defined here in this slide. Next slide, please.

Slide 32

Now look at things like gonorrhea rates by gender. The rates of gonorrhea went down for both males and females in 2022. Males continue to have higher rates than females. Males reported a rate of 178 per 100,000, which represents a 12% decrease from 2021. Females had a rate of 130 in 2022, which represents a decrease of 20% from 2021. Next slide, please.

Slide 33

Gonorrhea rates by age, so all age groups saw did decline in 2022 for gonorrhea. The highest rate remains in the 20- to 24-year-old age group at 553 per 100,000. Next slide, please.

Slide 34

Age-specific gonorrhea rates by gender, and so we can see that females under the age of 25 years of age continue to have higher rates of gonorrhea than males. Males record the highest rate among age groups older than the age of 25. The highest rates of gonorrhea in females are 20- to 24-year-olds, at 597 per 100,000. Next slide, please.

Slide 35

This is the plot that takes a look at gonorrhea rates by race and ethnicity and there continues to be large disparities in the rates of gonorrhea. The Black African American, non-Hispanic rates are 19.2 times higher than the white, non-Hispanic rate and the rate of black non-Hispanic was 1,102 per 100,000 compared to the white, non-Hispanic at 57 per 100,000. The American Indian Alaskan Native population reported a rate that was 9.5 times higher than the white, non-Hispanic at 547 per 100,000 and Asian Pacific Islanders had a rate that was 1.5 times higher than the white, not Hispanic at 89 per 100,000 and the Hispanic Latino population which can be of any race, had a rate that was 3.6 times higher at 205 for 100,000. Next slide, please.

Slide 36

Chlamydia decreased 2% in 2022 compared to 2021, which recorded the second decline in over a decade. This could be a true decrease in the number of cases being reported, but it could also reflect again some of the impacts that COVID-19 played and reduced preventative visits. Chlamydia is more likely to be asymptomatic than gonorrhea and syphilis, especially in females. And so as I kind of mentioned before with COVID, since COVID we at MDH as well as some of the data that's been coming out of the CDC has shown some interesting trends that as epidemiologist and as surveillance staff, we're still evaluating what some of those impacts might be. So while evaluating our data for STD's, keep that in mind that MDH and the CDC are still evaluating the impacts of COVID have played on trends and how diseases being reported to us. Next slide, please.

Slide 37

Now we're gonna take a look at chlamydia rates by county. Despite the decreases, all counties in Minnesota were affected by chlamydia, with all counties reporting at least three cases. So every single county in the state of Minnesota had at least three cases in 2022. The City of Minneapolis continues to have the highest rate at 1,267 per 100,000, followed by the city of

Saint Paul at 896. The seven County metro area, excluding Minneapolis and Saint Paul, had 344 per 100,000, and Greater Minnesota reported 288 per 100,000. Next slide, please.

Slide 38

The rates of chlamydia increased for males but decreased for females last year. We can see that males had a rate of 311 per 100,000, which is a 1% increase from 2021, which had a rate of 308. Females had a rate of 520 in 2022, which is a decrease of 4% from 541 reported last year. So males saw slight increase; females saw a decrease last year. Next slide, please.

Slide 39

The rates of chlamydia are highest amongst females. Females 20 to 24 years of age, continue to have the highest rate at 3,001 per 100,000. Males aged 45 to 49 reported the largest increase last year of over 13% when compared to 2021. So 45- to 49-year-old male saw the largest increase from last year. Next slide.

Slide 40

Please taking a look at race and chlamydia data - so we can see that there are also disparities in chlamydia data in Minnesota. The Black African American, non-Hispanic population had a rate that was 11.7 times higher than that of the white, non-Hispanic rate and the rate in the Black African American, non-Hispanic was 2,127 per 100,000 compared to the white, non-Hispanic at 182 per 100,000. American Indian Alaska native population had a rate that was 5.6 times higher at 1,014 per 100,000 and Asian Pacific Islander population reported a rate that was 2.2 times higher at 402 per 100,000, and the Hispanic population, which can be of any race again, had a rate 4.9 times higher at 895 per 100,000. Next slide, please.

Slide 41

Now we're gonna take a look in chlamydia and gonorrhea data among adolescents and young adults. That would be folks 15 to 24 years of age, and we can see now, next slide, please.

Slide 42

Chlamydia disproportionately impacts youth and young adults in Minnesota, and we can see that Chlamydia continues to disproportionately impact the 15- to 24-year-old age group. The 15- to 24-year-old age groups makes up only 14% of our state's population but account for 59% of all chlamydia cases reported in 2022. Next slide, please.

Slide 43

Gonorrhea also disproportionately impacts young adults and adolescents, again only making up 14% of the population, but accounted for 38% of all gonorrhea cases reported in 2022. Next slide, please.

Slide 44

This is again, that's just a nice a trend line overtime that looks at gonorrhea rates by gender and we can see that the rates for gonorrhea and chlamydia are higher in females when compared to male young and adolescent adults in Minnesota, 15 to 24 year olds. The rates for chlamydia and

females are 2,605 per 100,000 compared to males at 1001 per 100,000. The rates of gonorrhea in females is 504 per 100,000 compared to 367 per 100,000 in males. Next slide, please.

Slide 45

Summary of characteristics in adolescents and young adults for gonorrhea and chlamydia, and we can see that in adolescent and young adults, the majority of cases of chlamydia and gonorrhea are females at 69%. A little over one third (36%) report white, non-Hispanic as their race, followed by about one third (30%) that respond as Black, non-Hispanic, and 19% were unknown or more than one race. Adolescent and young adults accounted for 60% of chlamydia and 37% of gonorrhea cases in Minnesota. Next slide, please.

Slide 46

So summary of STD trends in Minnesota. From 2012 to 2022, the Chlamydia rate has increased 22%. The rate of gonorrhea has increased 165% and syphilis has increased 447%. Adolescent and young adults aged 15 to 24 years old continued to make up a majority of chlamydia and gonorrhea cases at 53%. Minnesota has seen a resurgence of syphilis over the past decade, with men who have sex with men and those coinfected with HIV being especially impacted, however the number of females impacted is near a record high for the last decade as well. People of color continue to be disproportionately affected by all STDs in Minnesota and nationwide. Disparities in rates of STDs are not explained by differences in sexual behavior, but are due to differences in health insurance coverage, employment statuses, and access to health care and preventative screening and treatment services. Next slide.

Slide 47

I did want to just highlight last year we did update our case report form, but I just wanted to let folks know that they can find that on our website, where we kind of highlighted a few more things when it comes to EPT and DGI or resistant cases being reported to Minnesota and I think that's all the updates I had for STDs this year. I'll transition and hand it off over to my colleagues.

HIV Presentation

Slide 48

Thank you, Khalid. My name is Nathan Blumenfeld. I'm an HIV epidemiologist at Minnesota Department of Health and I will be presenting highlights from the Minnesota HIV surveillance report for 2022. Next slide, please.

Slide 49

I know that Khalid just addressed this briefly but I'm gonna talk about it a little bit more. So though the COVID-19 national emergency is officially ending, it's effects continue to be felt. The COVID-19 pandemic in the US 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 that is mostly 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

activities. Given these data, these disruptions data for 2020 should be interpreted with caution. The overall number of HIV diagnoses in the US in 2020 was 17% lower than in 2019. Disruptions in clinical care services, patient hesitancy, and accessing clinical services shortages and HIV testing reagents and materials, shifting of partner services staff to COVID-19 activities, disruption in services provided by community-based organizations in 2020 likely led to under diagnosis of HIV in the US. Although state and local health departments quickly developed and implemented innovative strategies for HIV related testing and care services such as self-testing and telehealth during the first year of the COVID-19 pandemic, these strategies did not make up for declines and laboratory-based HIV testing. In addition, telehealth visits might not have included orders for lab testing due to social distancing recommendations where patients may have been reluctant to access testing during this time. Under reporting of laboratory test results to state and local HIV surveillance programs was not a major contributor to declines in diagnosis.

So many areas did continue to experience disruptions in 2021 and as the COVID-19 pandemic is still ongoing, more time and data are needed to accurately assess COVID-19 impact on HIV in the United States. And as Khalid said, assessments of trends in HIV diagnosis that include the year 2020 are discouraged. Next slide, please.

Slide 50

So for reference, we do use CDC defined transmission categories throughout this presentation. These represent the risk factor most likely based on available information to have been responsible for transmission of HIV to a given patient. Next slide, please.

Slide 51

Regarding gender identity, we use cisgender to mean that a person's gender identity aligns with the sex that person was assigned at birth and transgender to mean that a person's gender identity does not align with the sex that person was assigned at birth. While we follow CDC's transmission category hierarchy, we are working to use gender identity language to better represent HIV data in our state. Recognizing that there are situations when transmission categories may not accurately represent the identities of people living with HIV. These gender data are based in part on whether gender and identity are reported on case report forms and lab records. Only when these data are completely and accurately reported can we more fully understand the burden of HIV in every community. Next slide. please.

Slide 52

So now I'm gonna talk about new HIV diagnosis in 2022 in Minnesota. Next slide, please.

Slide 53

So in this report, the term new HIV diagnosis refers to Minnesota residents living with HIV who are diagnosed in a particular calendar year. In this case, 2022 and reported to Minnesota Department of Health. This includes people whose first diagnosis of HIV infection is AIDS or AIDS at first diagnosis. HIV diagnosis data are displayed by the earliest known date of HIV diagnosis. In the decade prior to 2020, there were an average of 300 new diagnosis per year trending down on average about 5 1/2 diagnosis per year. 2020 saw a 16% decrease in HIV

diagnosis from 2019 and what might be a rebound effect was seen in 2021. The 262 new diagnoses in 2022 are a possible return to trend. As discussed earlier may take more time and data analysis to accurately assess COVID-19 impact on HIV transmission over the last three years. Next slide. please.

Slide 54

Historically, about 80% of new infections diagnosed in Minnesota have occurred in Minneapolis, Saint Paul and the surrounding 7 county metropolitan area. In 2022, of 262 total HIV diagnosis 74% of the cases were in the seven county Twin Cities metro area, with 27% in Minneapolis, 14% in Saint Paul and 33% in the remaining suburban area excluding Minneapolis and Saint Paul. In Greater Minnesota, there were 69 newly diagnosed HIV cases across 26 counties. Next slide, please.

Slide 55

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 but accounted for 38% of newly diagnosed cases of HIV in 2022. Similarly, Hispanics of any race account for approximately 5% of the population but account for 14% of the newly diagnosed cases. Next slide, please.

Slide 56

Each year we calculate the rate of diagnosis for each racial or 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 Minnesotans had the highest rate of diagnosis in 2022 with 54.9 HIV diagnoses per 100,000 population among Black non-African born people. For African Americans who are not African born, this represents a rate that is 26 times higher than the rate and white, non-Hispanic population in Minnesota. The next highest rate was among American Indians, with the rate of people newly diagnosed with HIV of 19.8 per 100,000 people, 9.4 times the rate of white, non-Hispanic people. African born Black people had a rate of 17.2 diagnosis per 100,000 population, which is 8 times that of the white population and Hispanic people of any race have the next highest rate of newly diagnosed HIV cases in Minnesota at 14.8 per 100,000 people. This is a rate 7 times that of white, non-Hispanic people. Next slide, please.

Slide 57

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. On the left among 211 people assigned the sex of male at birth, 37 of the 2022 cases diagnosed in Minnesota are non-Hispanic, white seen in the dark blue, non-Hispanic, Black, non-African born in light green, and black African born males in light blue, made up about 35% of cases and Hispanic males of any race accounted for 17% of cases. On the right, among the 51 people assigned sex of female at birth, the disparities of new HIV diagnosis are even more apparent among people of color. They represented 77% of new HIV cases assigned female at birth, versus 63% of new HIV cases

assigned male at birth. Nearly half of female infections or 49% combined are black African born and non-African born. Next slide, please.

Slide 58

Here we look at cases and rates of the 262 new HIV infections by sex assigned at birth and reported sexual behavior. The proportion of cases among six among cisgender men has increased over the last few years. Cisgender men represents 78% of all new HIV diagnosis in 2022. The number of diagnoses amongst cis gender women has decreased to 50 in 2022 from more than 60 in 2021. Next slide, please.

Slide 59

In 2022, new diagnoses among men who have sex with men were largely made up of white (43%), black, African American, and Hispanic (22%) MSM. This is compared to total new diagnosis in Minnesota, where white people comprise 35% of new diagnosis and Hispanic people 14%. Next slide, please.

Slide 60

In 2022, there were 105 people diagnosed under the age of 30, accounting for 40% of all new cases, 94 or 90% of these were in people assigned male at birth. Age groups 20 through 24 and 35 through 39 had the largest number of new cases in 2022. Next slide please.

Slide 61

This slide depicts risk for all people diagnosed with HIV in Minnesota during the past decade. In 2022, cases where mode of transmission was reported men having sex with men was the most common accounting for 47% of all diagnoses and 77% of diagnoses with known modes of transmission. Mode of exposure was unknown or undisclosed in 39% of cases in 2022. The number of cases among people who inject drugs was 22 cases in 2022 and increased from 2020 and 2021, which continues the trend seen since 2019, when an outbreak began among persons who inject drugs, and Hennepin and Ramsey counties. Another outbreak in the Duluth region includes about half of cases that are among people who inject drugs. More details on these outbreaks later in this slide presentation. Next slide, please.

Slide 62

This slide describes HIV diagnoses 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 82 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 2022, there were 46 cases of newly reported HIV among foreign born people. This is about one in five of all new diagnosis, 18%. The majority of foreign-born cases in 2022 were from Africa, followed by Latin America, and the Caribbean. Next slide, please.

Slide 63

During the past decade, foreign born cases have a higher rate of late testers compared to US born cases. In 2021, among 89 foreign born cases, 38% of foreign born cases were late testers,

compared to 18% of US born cases. Over the decade, the range of foreign born cases that were late testers ranged from 27 to 46%. Percentage of late testers for 2022 includes only those progressing to AIDS through February 2023. Please note that cases diagnosed in 2022 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 2023. Next slide, please.

Slide 64

The ability to interrupt the transmission of HIV from mother to child via antiretroviral therapy and appropriate perinatal care is an important accomplishment in the history of the HIV epidemic. Without antiretroviral therapy newborn HIV infection rates range from 25 to 30% but decreased 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 several years. The last HIV perinatal transmission was in 2017. For the past decade, the number of births to pregnant parents living with HIV has ranged between 37 and 66 births. For 2022, there was a decrease to 37 births to pregnant people living with HIV with no perinatal HIV baby born to an HIV positive pregnant person in Minnesota during the year. Next slide, please.

Slide 65

Now we're going to discuss trends among adolescents and young adults between the ages of 13 and 24. Next slide, please.

Slide 66

The number of new HIV diagnosis among people assigned male at birth aged 13 to 24 has ranged from 30 to 62 cases over the past decade. Since the low in 2018, we've seen an increase of new diagnosis among males in this group, with 62 cases reported in 2022. In 2022, among adolescents and young adults assigned female at birth, there were seven cases. The total number of cases among adolescents and young adults were far higher from the previous year, with 69 in cases in 2022 compared to 61 cases in 2021. Next slide, please.

Slide 67

Looking at racial distribution among adolescents and young adults by sex assigned at birth, combining the most recent three years of data from 2020 through 2022, we had 155 cases assigned male at birth reported among adolescents and young adults, and 21 females reported in the 13- to 24-year-old age group. For people assigned male at birth, non-Hispanic African American in green accounted for half of the cases non-Hispanic, white in the dark blue and Hispanic of any race in the brown young adults accounted for about one in five cases each in the 13 to 20 age group. Among people assigned female at birth on the right, non-Hispanic white in the dark blue accounted for about 1/3 and black, African born in the light blue accounted for about 1/4 of the cases in the 13- to 24-year-old age group. Non-Hispanic African Americans in green accounted for about one in seven cases and non-Hispanic multirace accounted for one in 10 of the cases. Next slide, please.

Slide 68

For mode of exposure among people assigned male at birth in the 13 to 24 age group on the left. MSM sex was found to account for 90% of the cases while the combined risk of MSM and

IDU was estimated to account for 5% of cases and 3% was attributed to injection drug use mode of transmission. Among adolescent people assigned female at birth on the right most for most women, the HIV risk is unknown that 71% in the light blue, while in 19% of cases were found to have heterosexual contact as their mode of exposure in the dark blue. And 10% attributed to injection to drug use in the light green. Next slide, please.

Slide 69

Now we will discuss persons living with HIV and AIDS in Minnesota. Next slide, please.

Slide 70

So there are, as of Dec. 31, 2022, estimated to be 9,805 people alive and living with HIV or AIDS in Minnesota. This number includes 5,615, or 57%, living with an HIV infection that has not progressed to an AIDS diagnosis and 4,100 living with AIDS. This number also includes 2,702 people who were first reported with HIV or AIDS elsewhere and now live in Minnesota and excludes 1,734 people first reported with HIV or AIDS in Minnesota who now live out of state. Next slide, please.

Slide 71

You can see the distribution of race for people living with HIV in Minnesota compared to the distribution of race for MSM living with HIV in Minnesota. Of total people living with HIV, white people make up 42% or 65% of all MSM living with excuse me with HIV and Minnesota are white. 17% of all people living with HIV in Minnesota are Black African born, but only 1% of MSM living with HIV are Black African born. There are similar distributions of Black African American, American Indian, Asian Pacific Islander, Hispanic and other people. Between total people and MSM living with HIV. Next slide, please.

Slide 72

One particular population of interest in Minnesota that sets us apart from other states is our far larger foreign born HIV positive population. Between 1990 and 2022, 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 or AIDS in Minnesota, and by 2007 this number had increased to 1,126 people. In 2022, the total number of foreign-born people living with HIV/AIDS in Minnesota was 2,655, a 4% increase from 2021. 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 population in Minnesota and the need for culturally appropriate HIV care and prevention efforts. Non-US born persons make up 37% of all people living with HIV in Minnesota. Next slide, please.

Slide 73

Now to discuss briefly the HIV outbreaks. Next slide, please.

Slide 74

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 or works, people experiencing homelessness or unstable housing, people who exchange sex for income or other items they need. For more information, you can see our updated HIV statistics website described at the end of this presentation. Next slide, please.

Slide 75

Minnesota has also seen an increase of HIV in the Duluth area which is comprises a 30-mile radius around Duluth. Minnesota declared an outbreak in 2021 in the Duluth area 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 in the current outbreaks include people who use injection drugs or share needles or works, people experiencing homelessness or unstable housing, people who exchange sex for income or other items they need, and men who have sex with men. Next slide, please.

Slide 76

In addition to newly diagnosed HIV case counts by county, we have updated our statistics web page to include information on outbreak data details are available here. And I think that is about what we have.

Slide 77

So thank you and I believe we will start to address questions now.

Q&A

Slide 78

Yes, thank you, Nathan. We will now have time for a Q&A. As a reminder, the Q&A button will be in the top right of your screen right next to the settings. If we can't get to your question within our time today, we will upload a document to the website with all the questions along with the answers. And with that, presenters, are there any questions you would like to start off with?

Question: Do we have data about folks who identify as nonbinary or gender nonconforming?

I can go first for STDs, for the questions that I wrote down and let me know if I missed any. But the first question that I saw was do we have data about folks who identify as nonbinary or gender nonconforming? We do collect gender at time of report. Nonbinary or transgender data represents a very small number of cases that get reported MDH. MDH is also improving our surveillance system to ensure that this data gets reported accurately and entered correctly. Also, we are evaluating how many cases get reported to ensure providers know how to accurately report this data. This is something that we are mindful of and will continue to improve and evaluate ways to represent this in our data. Right now, it's really a small number

but we'll continue to improve and we're very mindful of that. I hope that answers that question.

Question: Does MSM for these data include transgender people?

The next question I have is does MSM for these data include transgender people? The way that MSM data gets computed for this would be folks that report their current gender as male at time of report, and then also report their gender of sex partners as male. This does include folks that obviously report that their gender of sex partners are male and female because they would still be folks that identify as males and are reporting gender sex partners to include males.

Question: Has syphilis ever been a standard test for prenatal care?

The next question I have is, has syphilis ever been a standard test for prenatal care? And so something that I wanna highlight pregnant people across Minnesota are at risk getting syphilis before or during pregnancy. MDH did update our provider guidelines and information on our website to recommend that all folks that are pregnant get screened at first prenatal care visit and then additionally early in their third trimester, as well as at time of delivery. That is what standard recommendations is for testing folks that are that come into the clinic as pregnant. So yes, we do recommend that folks get screened at first prenatal care visit, early in the third trimester, and at delivery.

Question: Does MDH have plans to address the racial disparities?

The next question I have for STDs is does MDH have plans to address racial disparities? I don't wanna get into too much detail cause if this is the question that's gonna be good for - well, better answered for our prevention staff who I don’t think are on this call today but we can answer that on the website. ▪MDH has been a media syphilis campaign targeting some of the communities that are disproportionately impacted. But again we'll have a more comprehensive response for that post on our website. So yeah so we'll go from there.

Question: Do you have any information on women where congenital syphilis is seen? Is there less prenatal care? Other aspects?

And the last question I saw for STD's is, do you have any information on women where congenital syphilis is being seen, is there less prenatal care or other aspects? So one thing that I do wanna highlight is in 2020, MDH did begin a congenital syphilis review board where every congenital case that's reported to MDH gets reviewed by the by members of the Review Board. The objective and goal to identify missed opportunities and identify potential interventions that could have been used to prevent the case moving forward. MDH doesn't break out congenital syphilis data too granular on our annual data release typically because we have just a small number of cases that as we break things out, aggregately things can become more identifiable and obviously we want to protect the individuals’ anonymity as much as possible. One thing that I can shed light on is that when it comes to what we're seeing though in the review board: one common theme unfortunately is that is that folks in many of the cases we do see limited or no prenatal care visits prior to delivery. So I hope that answers that question. If there were any others, I'll try and chime back in when I take a look at the Q&A message board.

Hi everyone. This is Hannah, HIV epidemiologist at MDH. We're just going through our questions here for HIV. Specifically, a couple things I want to start with is - there are a few questions about when our this will be on our website, so it is actually up today and Harry can correct me if I'm wrong. So we have we do 2 slide decks, which is our whole incidence slide decks and then our whole prevalent slide deck. So there is much more information in both of those slide sets and then we also represent our data with tables. So anyone van go and find that on our website and there's a lot more than what we presented today.

Question: When will cascade of care data be available?

Someone asked about our care continuum and our stages of care. So we present that data usually late summer, early fall. So that's our hope, to do a similar timeline this year. Our care continuum for 2022 will be released in a few months; we don't have that data today.

Question: If in a future year, you learn specific exposure for someone who was originally diagnosed as unknown exposure, do you revise the previous data?

We have a question here. I will just want to read it out loud. If in a future year, you learn specific exposure for someone who was originally diagnosed as unknown exposure, do you revise the previous data? Yes, every year we run our annual data but that also includes the data from previous years. So if we've learned we have an updated exposure then that data will be updated.

Question: Thoughts on what accounts for the large percentage of unknown mode of transmission for HIV amongst adolescent / young females? What accounts for the incredibly high percentage of people assigned female at birth whose mode of HIV transmission is unknown?

There were a couple points, a couple questions about the large amount of unknown exposures and the reason for that? We need that data collected and sometimes it's not able to be collected on case reports or in interviews with people - that's where we get our data from. So ideally, we get more and more of that data collected, but unfortunately that is just something we do have to deal with - we don't know the exposure for many people.

Question: Do we have data about folks who identify as nonbinary or gender nonconforming?

Thank you. This is Nathan again. So we do have a question here about do we have data about people who identify as non-binary or gender nonconforming? We have limited data on that based on the way data was collected. We do have new case report forms coming soon which do collect better data on gender identity so that we can better represent those populations going forward.

Question: Does MSM for these data include transgender people?

There's another question here about whether MSM for these data include transgender people? We do have some information in the slide decks that tries to break that out a little bit more. As we are able to collect better data on identity going forward, hopefully we'll be able to more thoroughly break that out.

Yeah, this is Cheryl Barber, epidemiologist. I wanted to further clarify the unknown status which can be high in the female population. A person could be interviewed, and they are unaware if the partners that they name actually have HIV. In order to get a status other than unknown they have to either know a person living with HIV that they name as a partner or know somebody as a partner that is a person who injects drugs, which are the high risk areas or somebody that had HIV via a blood donation or something like that. So then they would receive like a heterosexual status if they don't name somebody of the same gender.

Question: When do you consider an outbreak over?

I think there was a question about when do we consider an outbreak over? There are different standards for looking at that. That would be if we're not seeing increases in cases that are considered part of the case definition for an outbreak. For the Hennepin and Ramsey County outbreaks, our definition includes persons who inject drugs, persons who are living in an encampment, or those types of things. If we do not see increases in these cases over time, then we would possibly consider the outbreak over. But if we see increases after we had declared it over, we may go back to the outbreak response again. There's lots of considerations and working with outside agencies. For this, I'm not sure if Chrissy wants the answer any more about the outbreak.

Question: Any trend in PLHIV moving in versus out over last 5-10 years?

This is Nathan. There is a question about whether there's any trend in people living with HIV moving in versus out over the last five to 10 years. ▪I am not aware of any trends. That is something that we could look at more closely. People do seem to be moving around a lot, but there hasn't been any clearer trend that we've seen of people coming or leaving.

Question: Generally, what factors could lead to a county having high STD rates?

I can address one question with regards to STD rates by county. So the question was generally what factors could lead to a county having higher STD rates. Obviously there would need to be an increase in disease burden in a specific county. The one thing to remember is that 150 cases in Hennepin County is going to be a much lower rate because of the number of people that live in that county when compared to 150 cases in a remote county in our state. So, the thing to remember is that a rate is going to be computed by the incidence of disease that we had over time divided by the number of folks that live in that specific county. So obviously, we would need to see an increase in the number of disease as well as keeping in mind where we're seeing it demographically in our state.

Question: The dip in new HIV cases in 2020 makes sense from a reporting and prevention/testing standpoint. What are your thoughts around the dip in number of pregnant women with HIV in 2020?

Yeah, this is Cheryl Barber. And there's a question from Phoebe about the dip in new HIV cases in 2020. Makes sense from a reporting and prevention testing standpoint. What are your thoughts around the dip in the number of pregnant women with HIV and in 2020, ▪ I think they mean 2022, possibly. We did see a dip. We're not sure [why]. Maybe during the pandemic, pregnancy rates during the first two years were up and now they're at a low. With more data

and time, we'll be able to see that. But we do a match with everybody in our surveillance database to match them with birth certificates for that year. We haven't found any new cases. Over time we'll see if this trend continues or, as you can kind of see, it goes up and down throughout the years. But in the past 10 years, I think it's been around 60 cases per year but this year was a low year.

Thank you. Cheryl. Since we're at time I will close the session. As a reminder, a recording of this webinar will be posted to the website and you can also currently find the full reports and tables there now. We'll also include a document with all the questions submitted along with answers. Alright, thank you presenters and thank you everyone for attending this year's data release.

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