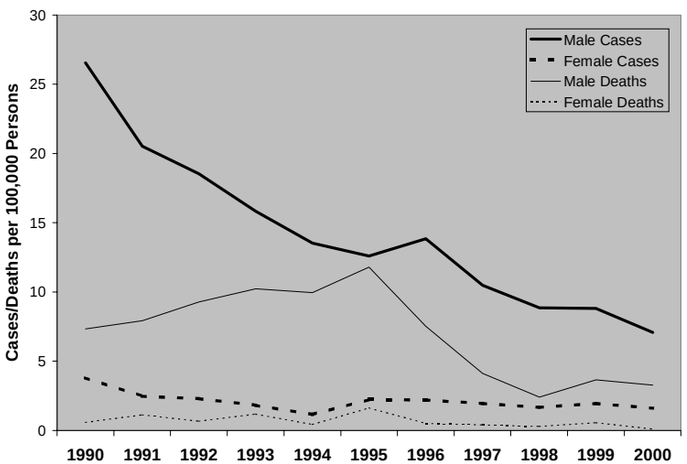
Utah Health Status Update:
Infectious Diseases Part 2: HIV/AIDS

Since the early 1980's, Human Immunodeficiency Virus infection (HIV) and Acquired Immunodeficiency Syndrome (AIDS) have affected thousands of Utahns, including nearly 1,000 deaths. The epidemic has changed becuse prevention efforts have successfully influenced individuals high-risk behavior, thus reducing the numbers of new cases. Effective treatment regimens have lengthened the life span of HIV infected people. Therefore, more people are living with HIV/AIDS and need preventive and treatment services in Utah. This Health Status Update reviews data from the 2001 HIV Surveillance Report and Community Epidemiological Profile that illustrate those changes.

- Newly diagnosed cases of HIV and AIDS in Utah have declined substantially since a peak in 1990 (Figure 1).
- HIV/AIDS deaths in Utah decreased after a 1995 peak, but leveled off during 1998-2000 (Figure 1).
- Both deaths and new cases have decreased, but the number of people living in Utah with HIV and AIDS continues to increase due to the longer life expectancy for people with HIV/AIDS (Figure 2).
- Most people living with HIV or AIDS in Utah are between the ages of 20 and 40 (77%) (data not shown). However, we know that many of them acquired infection during their teen age years, so prevention efforts need to focus on that age group as well.
- Most people living with HIV or AIDS in Utah are White (76%), but Black and Hispanic people are disproportionately represented. Of people living with HIV or AIDS, 13% are Hispanic and 9% Black (compared to 8%, and 1% of the population, respectively (2000 Census) (data not shown).
- The most common transmission risk group reported by people living with HIV or AIDS was "Men who have sex with men" (MSM) (59% of cases). "Injecting drug user" (15% of male cases and 35% of female cases), "Heterosexual contact" (9% of all cases and 50% of female cases) and "MSM/IDU" (7% of all cases) were the other most common risk groups reported (Figure 4).

HIV/AIDS Cases and Deaths

Figure 1. Cases and Deaths from HIV/AIDS reported in Utah per 100,000 persons, 1987-2000.

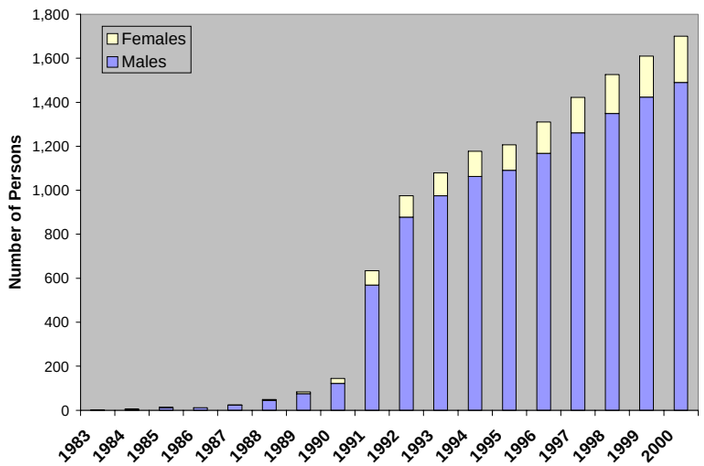


Note: Cases of HIV and AIDS were combined in the year of first diagnosis. Data on cases have been adjusted for reporting delay.

Source: Bureau of Communicable Disease Control, UDOH

Living With HIV/AIDS

Figure 2. Number of persons previously reported with HIV/AIDS and believed to be alive, Utah, 1983-2000.

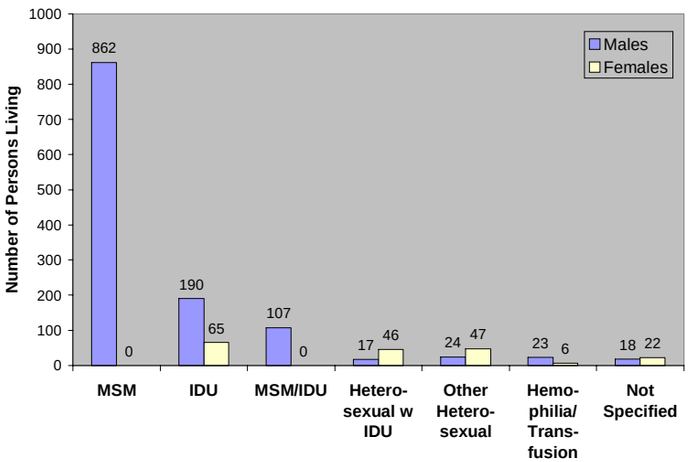


Note: Each bar indicates the number of people reported in Utah through that year and not known to have died. Data are cumulative and cannot be added across years. Detailed analyses of 2000 data indicate that the true number is lower (as in Figure 3). These data are presented to portray the year-by-year trend.

Source: Bureau of Communicable Disease Control, UDOH

Living With HIV/AIDS by Risk Group

Figure 3. Numbers of people believed to be living in Utah with HIV or AIDS as of the end of 2000 by Transmission Risk Group.



MSM - Men who have sex with men; IDU - Injecting drug user

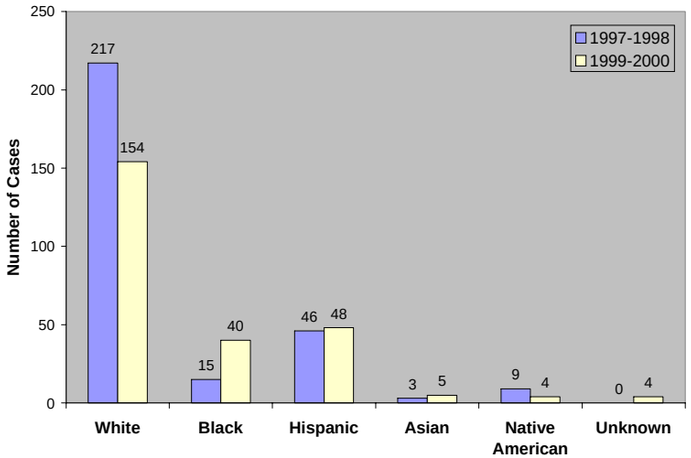
Note: Includes people reported with HIV or AIDS in Utah or moved to Utah after such report elsewhere, who are not known to have died or to have moved out of state.

Source: Bureau of Communicable Disease Control, UDOH

- About 125 new cases were reported in 1999 and in 2000. The 40 cases among Black people during 1999-2000 were double that reported in 1997-1998. Most of that increase could be attributed to cases among Black persons who immigrated to Utah from Africa (see Figure 4).

New HIV/AIDS by Race/Ethnicity

Figure 4. Numbers of cases of HIV/AIDS reported in Utah by race/ethnicity group and 2-year period, Utah 1997-2000.



Note: Cases of HIV or AIDS reported in Utah were grouped together as HIV/AIDS in the year that individual was first reported as either HIV or AIDS.

Source: Bureau of Communicable Disease Control, UDOH

These data illustrate the change in HIV/AIDS from an acute disease with almost certain death within a few years to a chronic disease. This brings a need for different services and approaches to delivering those services. Despite these changes, people continue to acquire HIV indicating the need for ongoing attention to prevention. The increase in newly reported cases among people who have moved to Utah from Africa is but one of many examples of how both prevention and treatment services need to be directed to populations that differ in language, beliefs and other culturally determined factors.

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