

EXECUTIVE SUMMARY

Recognizing North Carolina's diverse makeup is important to understanding the impact on the state of HIV/AIDS and other STDs because these diseases are disproportionately represented among minorities and the economically disadvantaged. According to census figures, North Carolina ranks as the 11th most populous state in the nation and has experienced rapid growth. It has the seventh largest non-white population in the nation. In 2004, the racial/ethnic makeup of the state was about 22 percent black or African American (non-Hispanic), 69 percent white (non-Hispanic), and 6 percent Hispanic, with the remaining proportion consisting of primarily American Indians and Asians/Pacific Islanders. Although American Indians comprise just over one percent of the state's population, this group represents the largest population of American Indians in the eastern part of the U.S. The state was ranked 37th in the nation for per capita income in 2005, with 14 percent of its population at or below the federal poverty level (2003-2004). North Carolina's foreign-born population increased from 4.4 percent in 2000 to 6.3 percent in 2004.

In 2005, 1,806 new individuals were reported with HIV disease (HIV/AIDS) in the state. Over recent years, North Carolina has averaged about 1,700 new reports annually, which is up from the number of cases reported in the late 1990s. Approximately, 30 percent of new individuals reported each year with HIV disease also represent new AIDS cases (i.e., HIV and AIDS were reported at the same time for the individual). This significant proportion of late diagnoses (i.e., AIDS) indicates the need for increased HIV testing within North Carolina. This supports recommendation to include voluntary HIV testing as part of routine medical examinations for all U.S. residents ages 13 to 64.

The overall HIV disease infection rate in 2005 was 21.1 cases per 100,000 persons. As seen with many other diseases, HIV is disproportionately distributed among the state's population. The 2005 rate of HIV infection for non-Hispanic blacks (61.4 per 100,000) was more than seven times greater than for whites (8.6 per 100,000). The rate of infection for Hispanics (24.1 per 100,000) was almost three times that for whites, and the rate for American Indians (20.6 per 100,000) was over two times that for whites. The highest rate of infection was found among black males (88.6 per 100,000). The largest disparity was found in comparing white and black females; the HIV infection rate for black females (37.3 per 100,000) was over 12 times higher than that for white non-Hispanic females (3.0 per 100,000). The ratio of male to female HIV disease reports has risen from 2.1 in 2001 to 2.6 in 2005. Much of the increase in HIV disease reports over the past few years was attributed to more male HIV disease cases being reported; the number of reports for females has remained fairly constant.

Risk of HIV transmission is very different for males and females; therefore it is important to discuss risk separately for each. In 2005, 66 percent of new adult and adolescent HIV disease reports for males was attributed to men who have sex with men (MSM), 7 percent to injecting drug use (IDU), 2 percent to MSM who also inject drugs (MSM/IDU); and 24 percent was attributed to heterosexual contact. For adult and adolescent females, heterosexual contact accounted for about 83 percent of HIV disease reports in 2005, while injecting drug use accounted for about 12 percent.

The proportion of male reports with MSM as a risk factor has increased over the past few years for all racial/ethnic groups. In 2005, MSM (including MSM/IDU) accounted for 88 percent of white non-Hispanic males, 59 percent of black non-Hispanic males and 62 percent of other males. The state's partner counseling and referral services (PCRS) program showed an increasing proportion of interviewed men who indicated MSM risk during follow-up of both HIV and syphilis cases. In 2005, 48 percent of interviewed males with HIV or early syphilis indicated MSM risk. According to Counseling and Testing System (CTS) data, those reporting MSM risk have consistently had the highest percent of HIV positive test results. In 2004, about five percent of males reporting MSM risk who tested at traditional test sites (TTS) were positive for HIV and about four percent of those who tested at nontraditional test sites (NTS) were positive.

Injecting drug use risk (including MSM/IDU) accounted for about 9 percent of male adult/adolescent HIV disease reports in 2005 and accounted for about 12 percent of female reports. In 2004, persons who reported IDU risk (males and females) had the second-highest positivity rate among those who received HIV testing at CTS sites (about 1.7 percent at NTS and about 0.7 percent at TTS).

Heterosexual contact as a primary risk accounts for 39 percent of all (male and female) 2005 HIV disease reports. As mentioned earlier, it was the principal risk for female cases (83%), especially younger female cases (92% of likely female adolescent exposures). Heterosexual HIV reports for 2005 were higher among black males (31%) and other minority males (32%) than among white males (8%). Indications of heterosexual risk-taking behavior can be found in the high rates of infection for other sexually transmitted diseases. In 2004, North Carolina ranked 6th in the nation in the rate of new gonorrhea cases. The male-to-female ratio for gonorrhea has remained stable and near 1.0, indicating the predominance of heterosexual transmission. Additionally, over 97 percent of new female syphilis cases and 66 percent of new male syphilis cases, interviewed through PCRS between 2001 and 2005, reported heterosexual activity.

While trends among new HIV disease reports indicate prevention needs, trends among AIDS cases and estimates of persons living with HIV or AIDS can indicate service and care needs. As of December 31, 2005, an **estimated** 29,500 persons were living with HIV or AIDS in North Carolina, including those who may have been unaware of their infection. Of the persons who have been reported and were listed as living at that time, 68 percent were males and 32 percent were females. With respect to race/ethnicity, 70 percent were black non-Hispanic; 25 percent were white non-Hispanic. Most of the people living with HIV were older, with 56 percent aged 25-44 years and an additional 39 percent being 45 years of age or older.

In 2005, 1,089 new AIDS cases were reported in North Carolina, essentially the same as the previous year (1,091). New AIDS cases in the state have increased substantially in the last few years. From 2000 to 2004, the national AIDS case rate increased by four percent (14.3 per 100,000 to 14.9) while in North Carolina, the AIDS case rate increased by 60 percent (8.3 to 13.3). In 2004, North Carolina ranked 13th among states for the rate of new AIDS cases. In 2003, North Carolina ranked 6th in the proportion of blacks among living AIDS cases. The reasons for the reported increases in AIDS reports in North Carolina are varied and likely represent several factors including: limited access to medical care, changes in HIV treatment effectiveness over time, and enhanced surveillance efforts to capture accurate and timely reports.

Eight consortia, along with other agencies and the state, provide Ryan White Title II services to HIV-infected persons across North Carolina. According to summary reports provided by service agencies, about 7,097 Ryan White Title II clients received or accessed funded services in 2005. In 2005, about 4,025 individuals were enrolled in the AIDS Drug Assistance Program (ADAP). The demographics of Ryan White Title II clients and ADAP enrollees were similar to the observed demographics of all persons listed as living in North Carolina with HIV or AIDS at the end of 2005.

In addition to HIV and AIDS, 10 other sexually transmitted conditions and diseases are reportable to the N.C. Department of Health and Human Services (DHHS). Chlamydia is the most prevalent STD, with 31,183 cases reported in 2005. Consistently, over 80 percent of reported cases are among females because they are more likely than males to be screened for the disease. Reported cases and rates have increased among females of all ages from 2001-2005, largely due to the increasing number of women who are screened each year as part of the Infertility Prevention Project.

The number of reported gonorrhea cases declined 10 percent over the past five years to 15,075 cases in 2005. Severe racial disparities exist in gonorrhea rates, though they have narrowed as the number of reported cases has decreased. In 2001, rates among black males were 32 times the rates for white males. The disparity decreased to 22 times higher in 2005. Disparities among females have remained relatively steady, with black female gonorrhea rates 10-14 times higher than rates for white females during the five-year period.

Early syphilis rates dropped from 15.1 cases per 100,000 population in 1999 to a low of 4.7 in 2003. Male early syphilis rates began to rise in 2004 and again in 2005, while female rates continued to decline. The increase in male syphilis rates in 2004 and 2005 is largely associated with an outbreak in Mecklenburg County. The county reported 30 male cases in 2003, which grew to 102 in 2005. Wake County also saw an increase in male cases during this time period (27 cases in 2003 to 56 cases in 2005). Further investigation of the Mecklenburg reports revealed that many of the male cases were linked to MSM activity. Among females, early syphilis cases in nearly all counties continued to decline. The marked exception was Mecklenburg County where female cases rose from 12 in 2003 to 40 in 2005.

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