

## **Winter Quarterly Report** ***January 2005***

**HIV/AIDS in New Mexico**  
Cumulative cases since 1981: (3,238)

### **Supplement to HIV/AIDS Surveillance (SHAS)**

In 1990, the Centers for Disease Control (CDC) initiated a cross-sectional interview project designed to collect behavioral surveillance data beyond what is found in the standard HIV/AIDS case report form. The Supplement to HIV/AIDS Surveillance (SHAS) project interviewed persons age 18 and older that were newly reported with HIV or AIDS to participating health departments. The data collected in SHAS have proved valuable in guiding HIV prevention and care programs. The data collection modules in SHAS include questions about demographics, drug and alcohol use, sexual behavior, HIV diagnosis and treatment, and use of social services.

Understanding the risk behaviors of the HIV-infected population has been a primary goal of the SHAS project. This goal takes on new importance in light of more people living with HIV/AIDS and the longer survival for those with AIDS. Prevention efforts are now challenged in trying to identify high-risk behavior and developing behavioral interventions that can effect changes that can be sustained over long periods of time, potentially for decades.

New Mexico has been involved in the SHAS project since its inception. Over time, the questionnaire has been modified to collect data on emerging issues related to the HIV epidemic. For instance, after highly active antiretroviral therapy (HAART) became available in the mid-1990's, questions were added regarding the use of and adherence to HAART. Since 1990, New Mexico has had 687 people living with HIV/AIDS participate in

the SHAS project. Of those, 174 were interviewed using the 6<sup>th</sup> and current version of the questionnaire. This report is based upon the analysis of the data gathered using the current questionnaire, conducted between 2001 and 2004. The CDC is currently analyzing nationwide data using all versions of the questionnaire.

The Health Management Alliance (HMA) in New Mexico recruited SHAS participants. The HMA is a non-profit healthcare system consisting of 5 partner organizations from each corner of the state and one specializing in services to Native Americans. The HMA is the major provider of HIV care in New Mexico, offering medical care, case management services, and other services to their enrollees.

Those individuals accessing HMA services may have influenced the recruitment of SHAS participants. A comparison of participant demographics to the surveillance data collected in the HIV/AIDS Reporting System (HARS) suggest that little bias was introduced by sampling within the HMA (Table 1). Surveillance data revealed that the majority of the HIV/AIDS population is White non-Hispanic (48%), followed closely by Hispanics (40%). This was the reverse case in SHAS, in that Hispanics had the highest participation (47%), followed by White non-Hispanic (44%). In both SHAS and HARS, Native Americans account for 7%, while Blacks were under-represented in SHAS (Figure 1). Asian/Pacific Islanders accounted for <1% in both SHAS and HARS.

Likewise comparisons of SHAS participants to the HARS revealed further similarities by mode of exposure (Figure 2). Men who have sex with men (MSM) were the majority of both SHAS participants (57%), and in HARS cases (62%). Injection drug users (IDU) were represented equally in both databases (11%), as were persons with heterosexual risk factors (9%). Persons who identified as both MSM and IDU accounted for 17% of participants in SHAS, but only 10% in HARS. Those with no identified risk factor, or a risk classified as "other" (hemophiliacs, received blood components/transfusion or transplants) represented the smallest percentages in both HARS and SHAS.

The SHAS module on socioeconomic status included questions on education level, employment history, and household income. About half of the participants had several years of college education. Of them, 21% had completed more than four years of college. The remaining participants had a high school education level or below (39%). A relatively equal number of participants were currently employed (47%) and not employed (53%). The majority of participants also stated their job situation had changed once they learned they were HIV positive (57%). These individuals stated they had "quit work because of illness or other problems related to HIV". Approximately 18% of New Mexicans are living at or under poverty level compared to 12% nationwide. Sixty-four percent of SHAS participants reported an annual household income of \$20,000 or less.

The alcohol and drug use module surveyed participants about the frequency of use, types of drugs used, and previous enrollment in treatment programs. Nearly all participants reported using alcohol at one time, with 73% having had alcohol in the past year. A majority of participants felt a need to cut down on alcohol use (56%).

Drug use questions were separated into 2 categories, those about injection drugs and those about non-injection drugs. Some drugs

are named in both categories due to their ability to be used via different modes. Eighty percent of participants reported having used some type of non-injection drug throughout their lifetime. Of these, participants reported use of marijuana and cocaine most frequently (Figure 3). Additionally, 51% reported use of non-injection drugs in the past year, compared to 31% who reported having injected drugs in their lifetime. The majority of these shared needles with another individual, including friends, lovers, family members, and persons they did not know (Figure 4). Seventy percent reported sharing with a friend suggesting that networks of users may be a potential source for maximizing HIV interventions.

Questions were also asked about past use of treatment programs. The term "treatment" included outpatient, residential, inpatient, 12-step or other self-help programs, and detoxification. Thirty-nine percent of all participants had enrolled in a treatment program sometime in their lifetime, and 32% of which had undergone treatment within the past year.

The next module of SHAS addressed sexually transmitted disease (STD) history and sexual behavior. Forty percent of participants reported having had sexual intercourse at age 13 or below, much of which occurred between the ages of 4 and 9. Another 40% reported their first sexual intercourse between 14 and 17, and the remaining 20% reported age of first sexual intercourse after age 18.

Between 1999 and 2003, the most commonly reported STD in New Mexico was chlamydia, followed by gonorrhea and syphilis. Conversely, SHAS participants primarily self-reported gonorrhea (40%) and syphilis (21%). The SHAS questionnaire included other pathogens not routinely followed by New Mexico's STD surveillance (Figure 5), such as genital or anal herpes and warts. SHAS revealed a relatively high prevalence (15%) of both these infections.

Persons who identify as MSM have a significant impact on the HIV epidemic in New Mexico. MSM comprise the largest proportion of participants in SHAS as well as in the surveillance data of HARS. Figure 6 describes the lifetime number of self-reported male sexual partners of this group. One fourth of the MSM reported having 40-99 male partners, while another 32% reported 100 or more male partners in their lifetime. These data reflect persons that identified as IDU/MSM as well. Together, MSM and IDU/MSM accounted for 78% of all SHAS participants.

The final module in SHAS examined HIV testing behavior and use of medical services. These questions explored perceptions about testing as well as any behaviors that may have contributed to their infection. Forty-five percent of participants stated they had previously tested for HIV prior to their first positive test; 90% of which received their test results. These data suggest that participants are aware of the risk of infection associated with their behavior and are, to some extent, concerned about their health.

SHAS also afforded an opportunity to compare established exposure risk with self-perceived mode of infection. CDC determines exposure risk based on a review of medical records or reporting by a provider. HIV and AIDS cases are counted only once in a hierarchy of exposure categories. Of the SHAS participants, 85% were categorized in HARS as MSM, MSM/IDU, or IDU. However, only 75% of SHAS participants stated MSM or IDU as their risk factor for HIV infection. This finding suggests that men classified as having been exposed through male-to-male sexual contact may consider themselves to be heterosexual because they also report having female sex partners. The remaining participants refused to reply, had an unlisted risk, or did not know what their risk was.

The majority of participants stated that someone recommended that they take an HIV

test (50%), while a similar amount decided of their own accord to be tested (42%). A few were required to take the test, though no reason was stated for the requirement (8%). Testing behavior can also be linked to a specific condition or incident that motivated the individual to seek services. Such reasons include illness, risky behaviors, needle sticks, and routine medical screenings. As shown in Table 2, 40% of participants stated that an illness was their reason for testing for HIV, with many having had an AIDS defining CD4 count (<200 cells/ul) at the time of their first positive test (44%). However, a clinician will recommend starting a person HAART when their CD4 count reaches 350 cells/ul. Defining late testers as having an initial CD4 count below 350 would potentially place more than half of participants into this group. Regardless of how a low CD4 count is defined, late testing is occurring in this population. Given the burden of advanced HIV disease, this has clear implications for access to services, cost of care, and mortality.

The SHAS project has provided valuable information on the demographics and risk behaviors of adults with HIV or AIDS from diverse populations. Such information will prove useful in planning, implementing, and evaluating HIV prevention activities, as well as in future resource allocation.

By no means does this report completely describe all of the data available from the SHAS project. If you have further interests in data from SHAS, please feel free to contact Vincent Zummo, HIV/AIDS Epidemiologist, New Mexico Department of Health at (505) 476-3509.

Table 1. Distribution of SHAS participants and HARS cases in New Mexico, 2001-2004

Region/County	SHAS Participants	HARS Database
Region 1, Northwest	6%	13%
Region 2, Northeast	4%	6%
Region 3, Southwest	8%	13%
Region 4, Southeast	<1%	7%
Bernalillo County	67%	45%
Santa Fe County	14%	13%

Table 2. Reason for HIV testing and initial CD4 count\*

Reason for testing	CD4 count (cells/ul)				Total
	<200	200-499	>500	Don't Know	
Illness	27	16	9	10	62
MSM or IDU	3	7	8	5	23
Sex partner is IDU	0	2	1	0	3
Sex partner is HIV	3	10	13	2	28
Sex partner worried I have HIV	1	1	0	0	2
Needle sharing partner is HIV	1	0	1	0	2
Surgery (pre-operative)	1	2	0	1	4
Needle stick/					
Occupational exposure	0	1	0	0	1
Blood donor	0	0	1	0	1
Offered screening test at a clinic	0	0	2	2	4
Started new relationship/					
Discontinued condom use	0	1	1	0	2
Pregnancy/Prenatal	0	1	0	0	1
Routine exam	0	0	3	0	3
Just curious	0	2	7	3	12
Other	2	1	3	4	10
<b>Total</b>	<b>38</b>	<b>44</b>	<b>49</b>	<b>27</b>	<b>158</b>

\*Excludes 17 participants that did not respond.

Figure 1. Participants by race/ethnicity

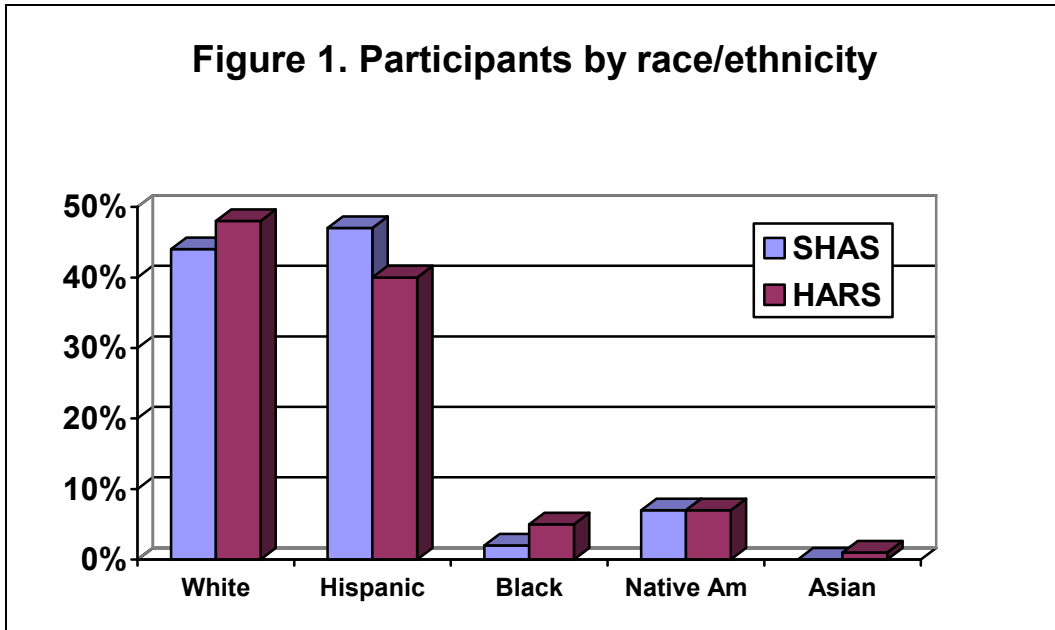
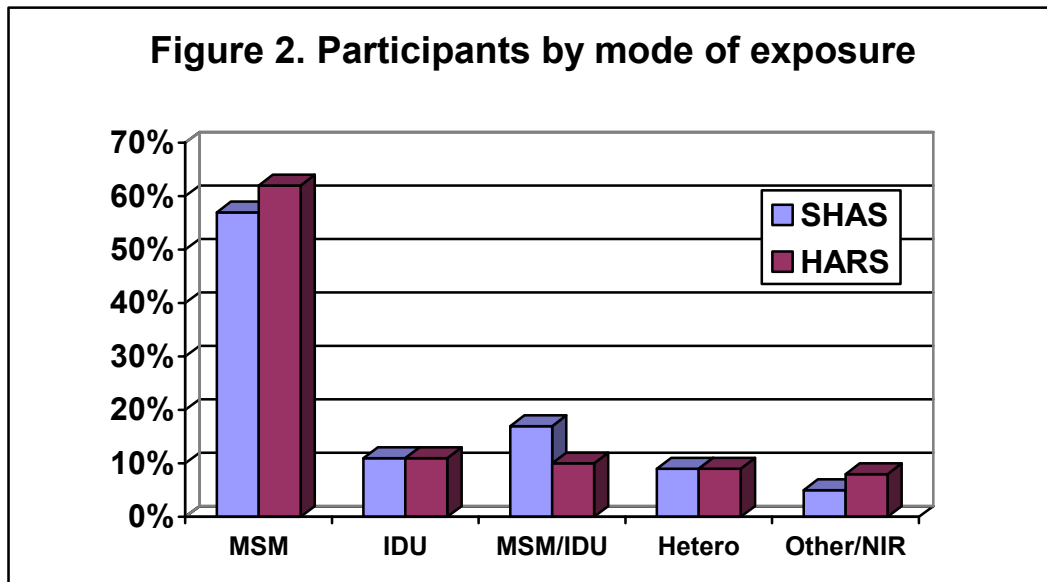
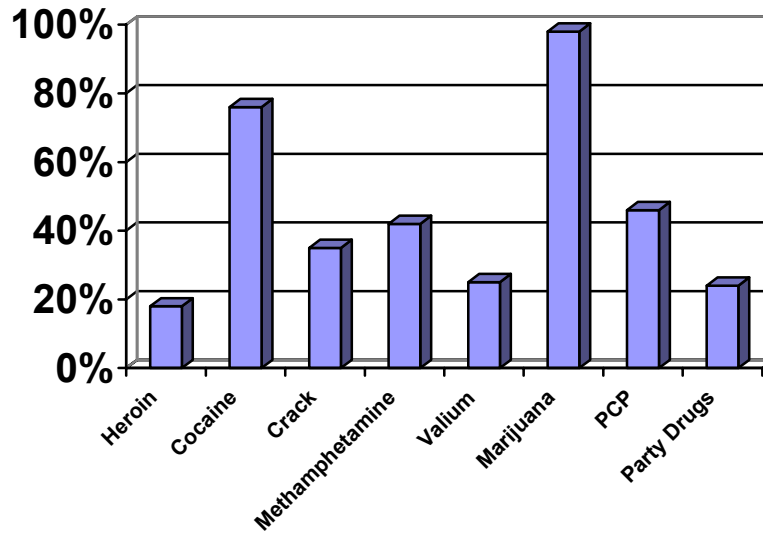


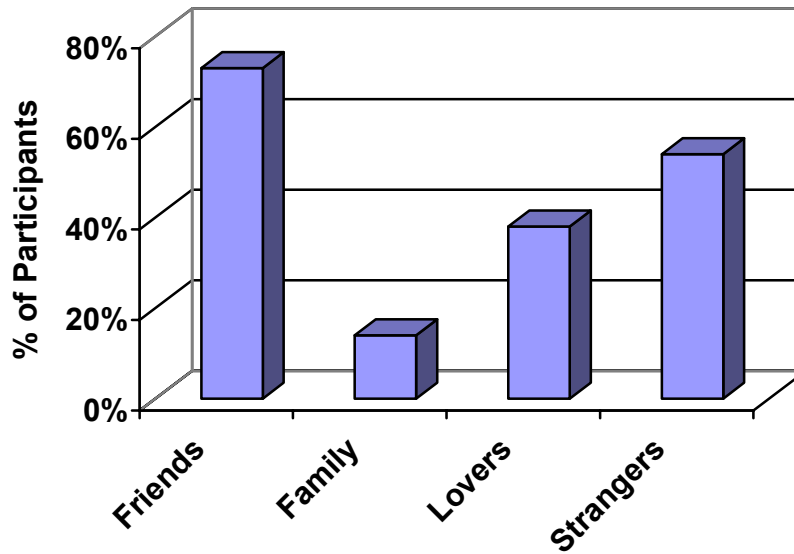
Figure 2. Participants by mode of exposure

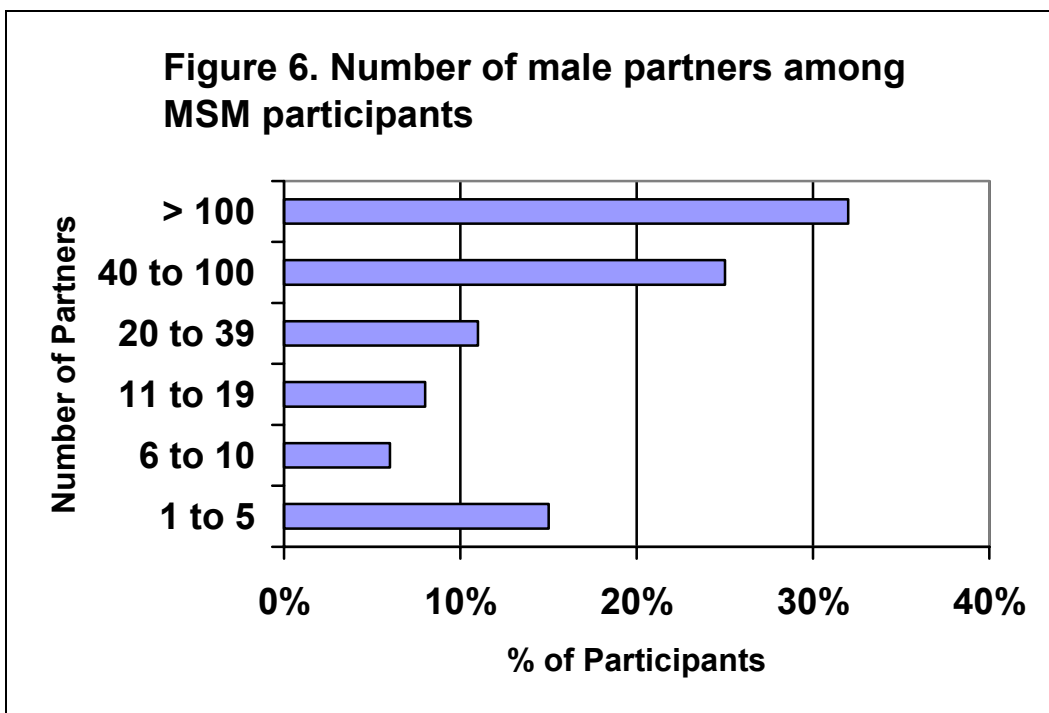
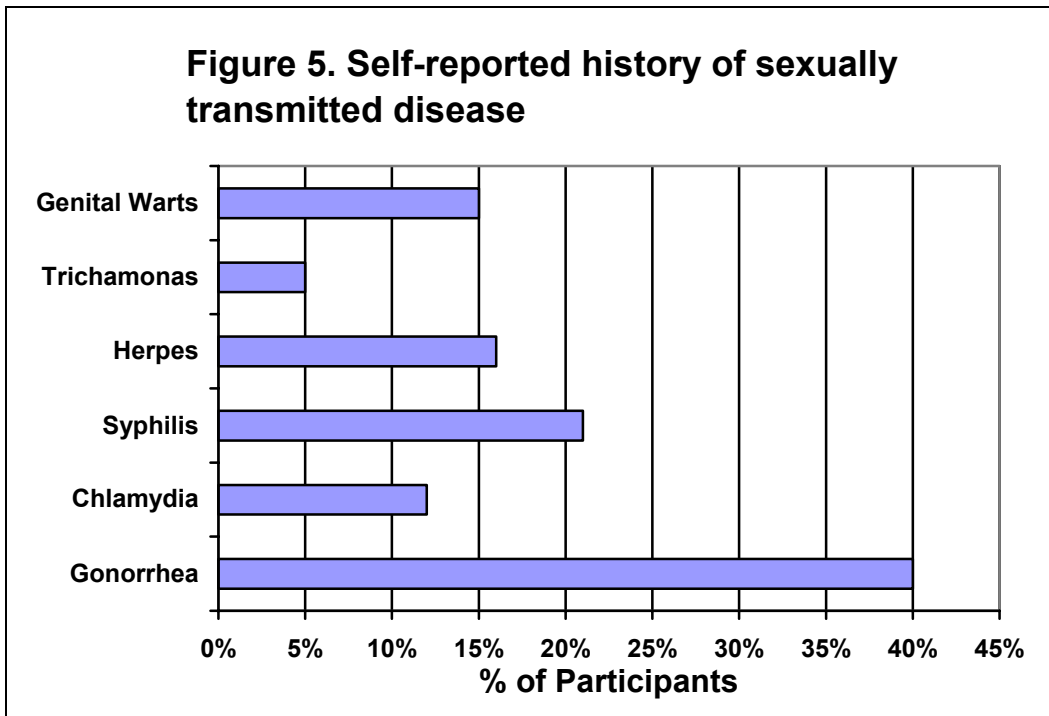


**Figure 3. Drug use among non-injection drug users**



**Figure 4. Reported needle sharing partners among injection drug users**





## HIV/AIDS IN NEW MEXICO FACT SHEET

Cases reported through December 31, 2004

Since 1981, New Mexico's health care services have helped us document a total of 4,485 individuals with HIV/AIDS, including 3,238 cases diagnosed in New Mexico. Living cases diagnosed in New Mexico, which are used by the U.S. Centers for Disease Control (CDC) to represent prevalent cases, are summarized below. Data including out-of-state diagnoses may provide a better reflection of local prevalence patterns and are available upon request.

<b>HIV/AIDS Cases Diagnosed in NM</b>	<b>Living Cases</b>			<b>Cumulative Cases</b>		
	<i>Number</i>	<i>% of total</i>	<i>Rate*</i>	<i>Number</i>	<i>% of total</i>	<i>Rate*</i>
<b>HIV/AIDS: Total</b>	<b>1949</b>	<b>100%</b>	<b>105.1</b>	<b>3238</b>	<b>100%</b>	<b>174.5</b>
<b>Type of Case</b>						
HIV	802	41%	43.2	847	26%	45.7
AIDS	1147	59%	61.8	2391	74%	128.9
<b>Gender</b>						
Male	1705	87%	186.9	2909	90%	318.9
Female	244	13%	25.9	329	10%	34.9
<b>Race/Ethnicity</b>						
White	904	46%	109.2	1636	50%	197.7
Hispanic	809	42%	101.6	1244	38%	156.2
Native American	132	7%	76.9	187	6%	108.9
Black	95	5%	262.8	158	5%	437.0
Asian/Pacific Islander	9	<1%	38.3	15	<1%	63.9
<b>County or Region**</b>						
Bernalillo County	884	45%	154.1	1562	48%	272.3
Santa Fe County	302	15%	224.5	524	16%	389.5
NW Region	253	13%	63.1	380	12%	94.8
NE Region	111	6%	77.1	180	6%	125.0
SW Region	273	14%	81.3	379	12%	112.9
SE Region	126	6%	47.3	180	6%	67.6
<b>Age at First Positive HIV Test</b>						
0-12 years	7	<1%	2.0	11	<1%	3.1
13-19 years	38	2%	18.4	41	1%	19.8
20-29 years	467	24%	190.5	670	21%	273.4
30-39 years	826	42%	331.2	1392	43%	558.1
40-49 years	469	24%	167.0	822	25%	292.8
50+ years	142	7%	27.3	302	9%	58.1
<b>Exposure Category</b>						
Men who have sex w/men (MSM)	1165	60%		2004	62%	
Injection drug users (IDU)	209	11%		334	10%	
MSM / IDU	188	10%		325	10%	
Heterosexual Contact	167	9%		219	7%	
Other Identified Risk	21	1%		59	2%	
No Identified Risk	185	9%		279	9%	
Children (<13 at diagnosis)	14	<1%		18	<1%	

\*Rates per 100,000 based on U.S. Census Bureau data for July 1, 2002; \*\*Residence at diagnosis.

HIV/AIDS Epidemiology Program, Infectious Disease Epidemiology Bureau, NM Dept. of Health  
 1190 St. Francis Dr., Santa Fe, NM 87502-6110  
 Phone (505) 476-3515 • Fax (505) 476-3544  
<http://www.health.state.nm.us/hiv-aids.html>