HIV infection

During 2013, the number of reported newly-diagnosed infections among Oregon residents (215) fell just under 20% from 2012 (263). However, HIV infection remains an important public health problem in Oregon. From 1981 through 2013, 9,430 Oregonians had reported cases of HIV infection; 42% of those died by the end of 2013. Since 1997, an average of 271 new cases were reported each year among Oregon residents. The number of Oregon cases* of people living with HIV has continued to increase each year, nearly doubling from 2,681 in 1997 to 5,525 in 2013.

Recent diagnoses (2009–2013)

About half (49.2%) of those diagnosed with HIV during 2009–2013 were Multnomah County residents at the time of diagnosis. During this period, statewide, men were about eight times more likely than women to be diagnosed with HIV. The average age at diagnosis was 38 years.

Age at HIV diagnosis in Oregon (2009–2013)

The rate of new diagnoses during 2009–2013 was 3.3 times higher among blacks and was 1.7 times higher than for white, non-Hispanics; other races and ethnicities accounted for roughly 5% of all diagnoses.

Among all reported cases in men, men who acknowledge sex with other men (MSM) accounted for 71% of cases diagnosed during 2009–2013 (762/1,071). Other presumptive transmission categories include men who use injection drugs (4%), MSM who also use injection drugs (10%), and men who likely or possibly† acquired their infection from heterosexual transmission (5%). About 10% of recent male diagnoses lacked sufficient information to assign a transmission category. Among female cases, injection drug users accounted for 22% of cases and women who likely or possibly‡ acquired their infection through heterosexual transmission accounted for two-thirds (74%) of cases. The remainder included cases of maternal-fetal transmission and cases that lacked sufficient information for classification.

Oregonians living with HIV/AIDS

As of Dec. 31, 2013, 5,525 people who resided in Oregon at the time of HIV diagnosis were believed to be living. More than half of those resided in Multnomah County at the time of their diagnosis.

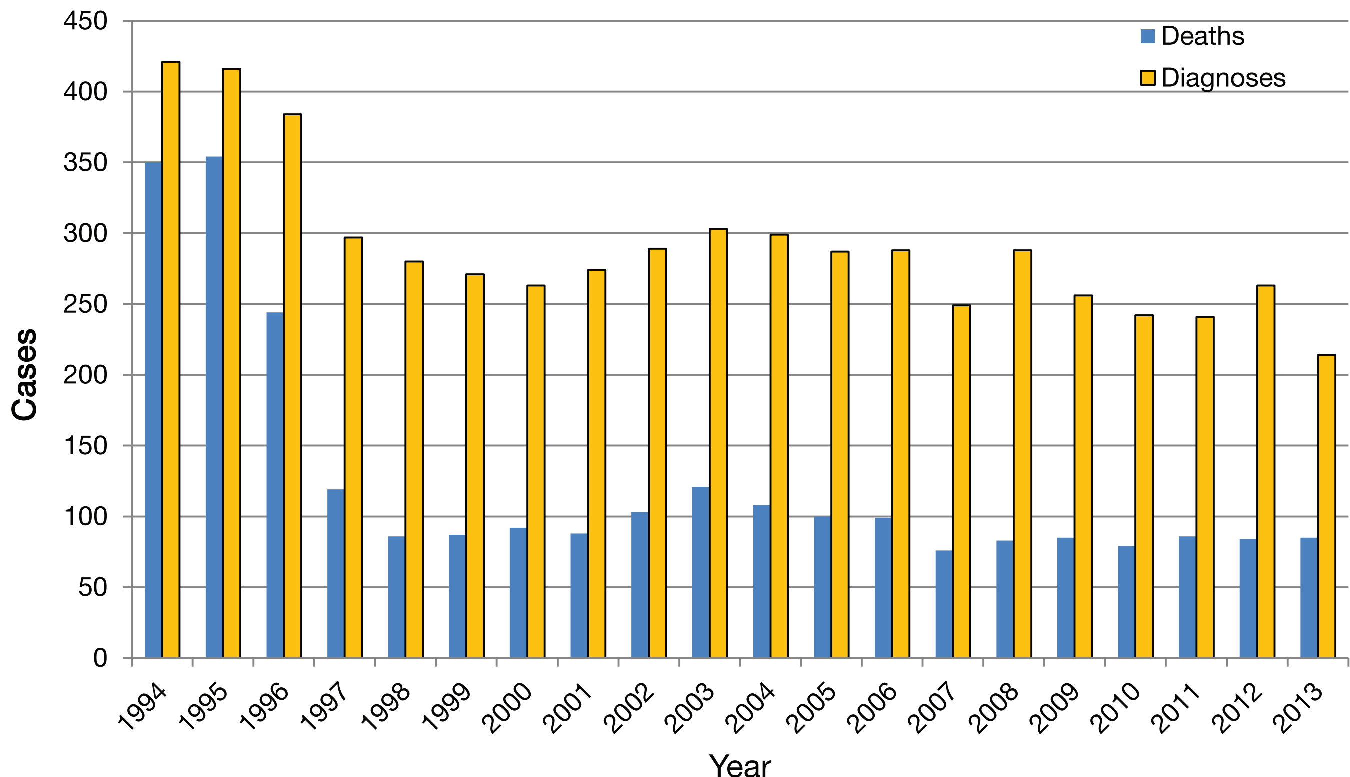
* For this report, a "case" is defined as an Oregon resident diagnosed with HIV infection (including AIDS) before being diagnosed in another state. Only those cases reported to the Oregon Health Authority HIV Program were included. People living with HIV in Oregon not counted in this report include those who resided in another state when they were diagnosed and as many as 1,000 or more people who are thought to be infected but have yet to be tested (Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data — U.S. and 6 U.S.-dependent areas — 2010. HIV Surveillance Supplemental Report 2012;17 (No. 3, Part A). Available at www.cdc.gov/hiv/topics/surveillance/resources/reports/. Published June 2012.

** Approximately 29% of black/African American cases are believed to have immigrated to the U.S. after becoming infected in another country

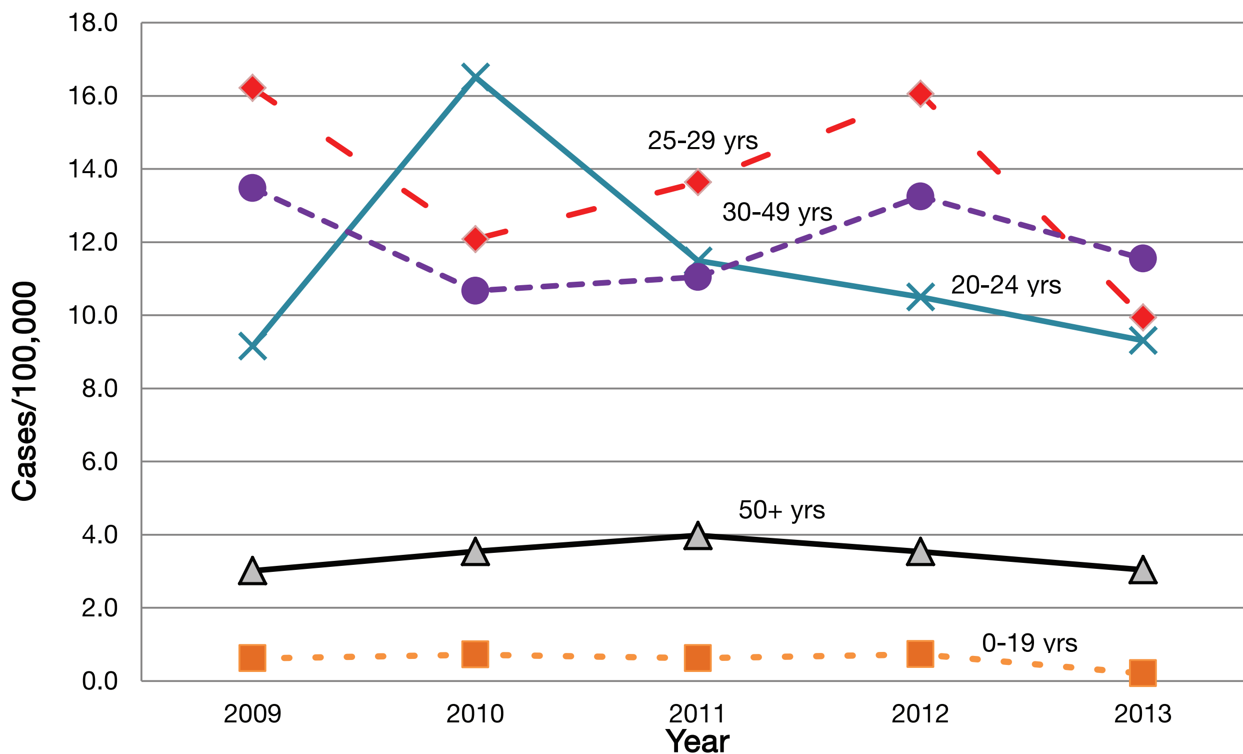
† Includes men who affirmed having sex with women and denied injection drug use, transfusions or transplants during the time they were not being adequately screened for HIV.

‡ Includes women who affirmed sex with men and denied injection drug use, sex with men or transfusions or transplants during the time they were not being adequately screened for HIV

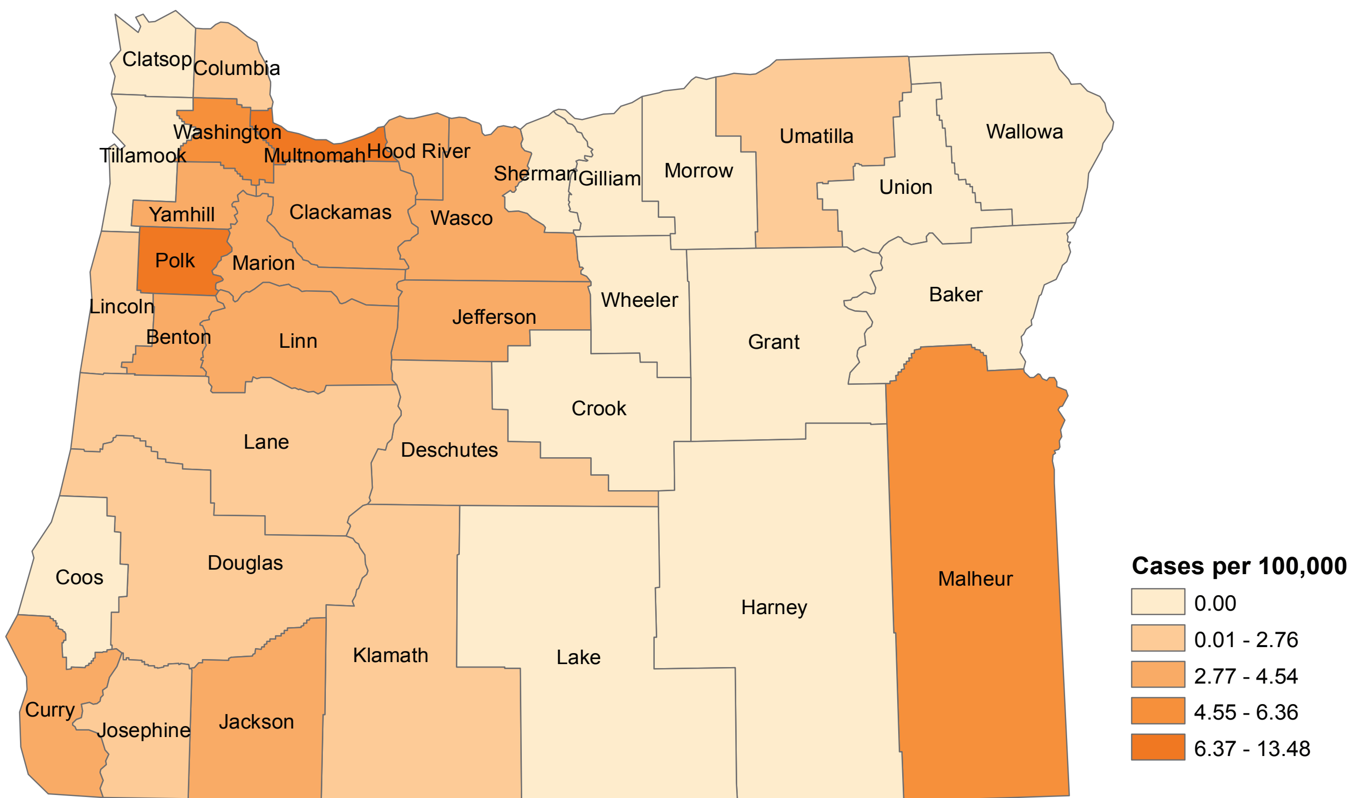
Oregon cases* of HIV infection, diagnosis and deaths: 1994–2013



Age at HIV diagnosis in Oregon: 2009–2013



People living with HIV or AIDS by county of residence at diagnosis: Oregon, 2013



Prevention

Primary prevention strategies aim to prevent a person from becoming infected in the first place by:

- Delaying age at onset of sexual activity;
- Decreasing the number of sex partners;
- Using condoms properly from start to finish when having sex;
- Refraining from injection drug use;
- Avoiding needle or "works" sharing with others, using only clean needles and works, and acquiring new sterile needles from pharmacies or needle exchanges if a person uses injection drugs;
- Providing assistance with drug and alcohol cessation.

Providing post-exposure prophylaxis (PEP) to eligible persons a one-month supply of HIV medication that may prevent infection if started within 72 hours of the sexual or occupational bloodborne exposure;

- Providing pre-exposure prophylaxis (PrEP) to some uninfected persons with very high ongoing risk of infection (daily antiviral medication intended to prevent infection if exposure occurs);
- Taking HIV medications during pregnancy if infected;
- Foregoing breastfeeding if infected;
- Rapid identification and treatment of new cases can also be considered primary prevention when it results in timely treatment of a newly infected person that averts transmission to a sex partner.

Secondary prevention strategies aim to eradicate existing infections by:

- Suppression of viral load by treatment of all HIV-infected persons, leading to decreased rates of secondary transmission;
- HIV screening: Unites States Preventive Health Service recommends screening everyone 15–65 years of age at least once and more often for people with ongoing risks such as multiple sex partners, sex with men (MSM), or injection drug use.