State of Alaska Epidemiology Bulletin

Department of Health
Heidi Hedberg, Commissioner
Robert Lawrence, MD, MA, CMO

3601 C Street, Suite 540
Anchorage, Alaska 99503

Division of Public Health
Lindsey Kato, MPH, Director

https://health.alaska.gov/dph/Epi
24 Hour Emergency (800) 478-0084
Local (907) 269-8000

Editors:
Joe McLaughlin, MD, MPH
Louisa Castrodale, DVM, MPH

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HIV Update — Alaska, 2020–2024

Background

Approximately 1.2 million people in the United States are living with human immunodeficiency virus (HIV) infection, and approximately one in seven are not aware that they are infected.[1] In 2022, 67% of new HIV infections in the US were among gay, bisexual, and other men who have sex with men (MSM), 22% were among persons with heterosexual contact, and 7% were among persons who inject drugs (PWID).[1] MSM, PWID, and individuals engaging in barrierless sexual contact with persons living with undiagnosed or untreated HIV remain at elevated risk of acquiring HIV. This report provides an overview of HIV cases diagnosed in Alaska from 2020–2023, a summary of 2023 data, and provisional 2024 data. A summary of cases reported during 1982–2019 is available.[2]

Methods

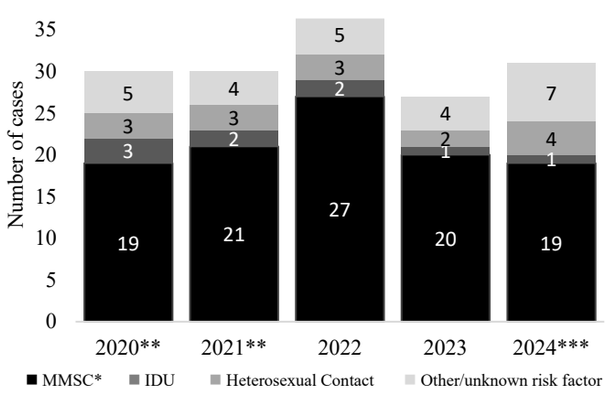
HIV and acquired immunodeficiency syndrome (AIDS), or stage 3 HIV infection, are reportable conditions in Alaska. The Section of Epidemiology (SOE) receives reports from health care providers for persons newly diagnosed with HIV and those newly accessing HIV care services in Alaska.[3] All persons newly diagnosed with HIV are offered an interview to assess risk factors and identify sexual partners, needle-sharing contacts, and others who could benefit from HIV testing and referral to pre-exposure prophylaxis (PrEP). Case analysis and cluster detection are conducted by SOE; clusters are determined by epidemiologic and/or molecular linkage of ≥3 cases based on the Centers of Disease Control and Prevention's (CDC) national priority criteria.[4] Case and partner services data are recorded in two secure SOE databases.

Summary of HIV Cases (2020-2023)

From January 1, 2020 through December 31, 2024, a total of 351 cases of HIV were reported to SOE. Of these, 124 (35%) were initially diagnosed in Alaska (Figure).

In 2023, 82 cases of HIV infection were reported to SOE. Of these, 27 (33%) were newly diagnosed in Alaska, yielding an incidence of 4 cases per 100,000 persons statewide. The remaining 55 reported cases (67%) were persons with a prior out-of-state diagnosis. Among the 27 persons newly diagnosed with HIV, the median age at diagnosis was 34 years (range: 15–67); 25 (93%) were male; 15 (56%) reported a race other than white; 14 (52%) reported male-male sexual contact (MMSC); 5 (19%) were diagnosed with stage 3 HIV infection (AIDS) at the time of their initial diagnosis; 22 (82%) were linked to HIV care within 30 days of diagnosis, 25 (93%) within 91 days, and 26 (96%) within 182 days; and 23 (85%) had laboratory evidence of viral suppression within 6 months of diagnosis.

Figure. Newly Diagnosed HIV Cases by Transmission Category and Year of Diagnosis — Alaska, 2020–2024



HIV Cluster Detection and Response

Since 2020, HIV clusters have been reported in two public health regions. In the Fairbanks/Interior region, a cluster monitored during 2021–2024 included 25 cases, with 22 (88%) newly diagnosed in Alaska. Of these 25 patients, 23 (92%) reported MMSC, 14 (56%) had ≥1 concurrent bacterial sexually transmitted infections (STI) at the time of their HIV diagnosis, and 13 (52%) had a documented negative HIV test in the 24 months preceding their HIV diagnosis. All living persons associated with this cluster have laboratory evidence of viral suppression. Cluster response efforts included a CDC-supported rapid qualitative assessment (RQA) to assess factors contributing to HIV transmission and to identify facilitators and barriers to prevention and care services. One key RQA finding included missed opportunities and gaps in HIV prevention services.[6]

In the Anchorage/Mat-Su region, a cluster involving 11 newly diagnosed cases occurred during 2021–2024. Among 11 persons, 8 (73%) reported MMSC, 9 (82%) had ≥1 outpatient healthcare visits <12 months before their HIV diagnosis, 1 (7%) had a current PrEP prescription at the time of diagnosis, and 9 (82%) currently have laboratory evidence of viral suppression.

Discussion

This report highlights ongoing concern for new HIV transmission and the importance of early linkage to care to support better health outcomes and viral suppression. Recent HIV clusters revealed prevention gaps and underscore the need for improved HIV prevention strategies. Broad HIV prevention awareness campaigns, PrEP education and provider training, and accessible PrEP care services are essential in preventing HIV transmission.

Recommendations

1. Routinely discuss sexual and risk histories during HIV, hepatitis, and STI testing or treatment encounters.[1,5] This includes reviewing types of sex, barrier use, substance and needle use, and known partner histories, including their sexual partners and substance use.
2. Provide post exposure prophylaxis (PEP) and PrEP education and counseling during routine care visits, and re-counsel during HIV, hepatitis, and STI testing or treatment encounters.
3. Prescribe PrEP to persons at increased risk of HIV infection, and to those who request it, regardless of disclosed risk factors.
4. Test persons at increased risk for HIV infection, including PWID and their partners, at least annually.[7] Test persons with increased risk every 3–6 months, with ongoing PrEP counseling.[7]
5. Conduct testing during healthcare visits, including emergency departments and correctional centers.
6. Test all pregnant women early in every pregnancy, and retest during the third trimester if they are at increased risk of HIV.[7]
7. Report confirmed and suspected cases of HIV to SOE within 2 working days via fax (907) 561-4239 or phone (907) 269-8057.

References

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(Contributed by: Sarah Brewster, MSW, MPH; Taylor Holsinger, MPH; and Elizabeth Ohlsen, MD, MSc; Alaska Department of Health.)