

Alaska HIV Prevention Plan

2007-2009



State of Alaska
Department of Health and Social Services



The *2007-2009 Alaska HIV Prevention Plan* has been developed by the Alaska HIV Prevention Planning Group with support from the State of Alaska HIV/STD Program and funding from the federal Centers for Disease Control and Prevention. If you would like copies of this document or additional information please call the Section of Epidemiology HIV/STD Program at (907) 269-8000 or visit the website at <http://epi.alaska.gov/hivstd/hppg>.



Dear Alaskan:

The Alaska HIV Prevention Planning Group is pleased to present the *2007-2009 Alaska HIV Prevention Plan*. We are providing both our recommendations and the data and information that shaped them to help guide and sustain effective HIV prevention activities throughout the state. Our goal is to prevent new HIV infections in Alaska.

Continued progress towards this goal requires contributions from all sectors. The strategies and interventions proposed in this *Plan*, a number of which will be carried out by local organizations with State grants of federal funds, are a limited part of the overall effort. Ultimately, the knowledge, attitudes, and behaviors that help individuals prevent infection are promoted and supported by families, friends, churches, health care providers, tribal health organizations, social groups, schools, public policy-setting bodies and communities.

The sexual and injection behaviors that place individuals at risk for HIV infection occur not in isolation but within the broader context of our communities. Changing the social factors that contribute to risk behavior, eliminating stigma and discrimination against those infected and affected by HIV, and supporting lifelong healthy behaviors are all critical to preventing new HIV infections. Persons who are living with HIV can make important contributions to raising awareness about the epidemic. Communities can play an important, positive role in educating their members about preventing transmission of HIV and ensuring that the voices of persons living with HIV are not silenced by fear of discrimination.

It is our sincere hope that no more Alaskans will become infected with HIV. We encourage all citizens to take part in local prevention activities, to increase awareness and understanding of HIV/AIDS, and to show compassion for those infected and affected by HIV and AIDS. Act within your own family, work place, social groups, or community organizations to make this become the reality in Alaska.

Sincerely,

Hugh Brown, III

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2007-2009 List of Acronyms

AAC	Alaska Administrative Code
ACDP	AIDS Community Demonstration Projects
ADA	Alcoholism and Drug Abuse Program
ADAM	Arrestee Drug Abuse Monitoring Program
ADAP	AIDS Drug Assistance Program
AI/AN	American Indians and Alaska Natives
AIDS	Acquired Immune Deficiency Syndrome
AK	Alaska
ANHC	Anchorage Neighborhood Health Center
ANTHC	Alaska Native Tribal Health Consortium
ASD	Anchorage School District
ASO	AIDS Service Organization
AYPF	Alaska Youth and Parents Foundation
BART	Becoming a Responsible Teen
CBAE	Community Based Abstinence Education
CARE Act	Ryan White Comprehensive AIDS Resources Emergency Act
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CDP	Center for Drug Problems
CHA/P	Community Health Aids/Practitioners
CRCS	Comprehensive Risk Counseling Services
CSA	Community Services Assessment
CT	(HIV) Counseling and Testing
CTRS	(HIV) Counseling, Testing, and Referral Services
DASH	Division of Adolescent and School Health
DBH	Division of Behavioral Health
DEBI	Diffusion of Effective Behavioral Interventions Project
DEED	Department of Education and Early Development
DHSS	Department of Health and Social Services
DIS	(Public Health) Disease Intervention Specialist
DJJ	Division of Juvenile Justice
DOC	Department of Corrections
EIS	Ryan White Early Intervention Services
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment Services
Four A's	Alaskan AIDS Assistance Association
FY	Fiscal Year
H/A	Health Alaska 2010 Indicators
HAART	Highly Active Antiretroviral Therapy
HC/PI	Health Communication/Public Information
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus

HE/RR	Health Education and Risk Reduction
HIV	Human Immunodeficiency Virus
HIVCT	HIV Counseling and Testing
HPPG	Alaska HIV Prevention Planning Group
HRSA	Health Resources and Services Administration
IAA	Interior AIDS Association
IDU	Injection Drug User
IEP	Inmate Education Program
IHS	Indian Health Service
ILP	Infant Learning Program
IND	Individual Health Education and Risk Reduction
ISAP	Inmate Substance Abuse Program
IV	Intravenous
MCH	Maternal Child Health
MOARHC	Municipality of Anchorage Reproductive Health Clinic
MS	Multiple Session
MSM	Men Who Have Sex With Men
OR	Outreach
PCM	Prevention Case Management
PCRS	Partner Counseling and Referral Services
PLWHIV	People Living With HIV
POL	Popular Opinion Leader
POWER	Peer Outreach Worker Education and Referral Program
PN	Partner Notification
PS	Partner Services and Disease Intervention
RAPP	Real AIDS Prevention Project
RARE-T	Reducing AIDS Risk Effectively in Teens
RW	Ryan White Comprehensive AIDS Resources Emergency Act
SCSN	Statewide Coordinated Statement of Need
SISTA	Sisters Informing Sisters on Topics about AIDS
SPNS	Special Projects of National Significance
SPRANS	Special Projects of Regional and National Significance
SS	Single Session
STD	Sexually Transmitted Disease
TB	Tuberculosis
TLC	Together Learning Choices or Teens Linked to Care
VOICES/VOCES	Video Opportunities for Innovative Condom Education and Safer Sex
WIC	Women, Infants, and Children
WIDP	Women and Infants Demonstration Projects
YKHC	Yukon-Kuskokwim Health Corporation
YRBS	Youth Risk Behavior Survey

Chapter 1

Introduction



2007-2009 Alaska HIV Prevention Plan

Chapter One: Introduction

HIV Prevention Successes and Current Challenges

June 2006 marked the 25th anniversary of the first cases of what would become known as AIDS. In 2006, more than 1 million persons are estimated to be living with HIV/AIDS in the United States (CDC, 2006a). With the advent of highly active antiretroviral therapy (HAART) in the mid-1990s, the overall progression of HIV infection to AIDS and from AIDS to death slowed for those in treatment. Persons with HIV infection can potentially live longer, healthier lives with the therapies that are currently available. This underscores the importance of early diagnosis and entry into care, as well as the need for prevention services for the growing population of persons living with HIV.

The development of alternatives to serologic testing for HIV (oral fluid, urine, finger-prick and rapid tests) has facilitated HIV testing in a wide range of clinical and community settings thus making HIV testing more accessible. Widespread availability and use of HIV testing has resulted in approximately 50% of persons aged 15-44 years in the U.S. reporting that they have had an HIV test. Yet despite the uptake in HIV testing, the Centers for Disease Control and Prevention (CDC) estimates that as many as a quarter of a million persons in the U.S. currently have HIV but are unaware of their infection. Persons with HIV who are unaware of their infection may transmit the virus unknowingly to others and are at considerable risk for developing AIDS. The challenge remains not only to increase the accessibility of testing, but to promote testing for persons who may have been exposed to HIV but who do not perceive their risk, and persons aware of their risk who defer testing for other reasons.

The number of new HIV infections in the U.S. is estimated to have remained stable at 40,000 per year since the early 1990s, compared to the more than 150,000 cases per year occurring in the mid-1980s. Nationally, perinatal transmission of HIV has been greatly reduced through routine HIV screening of pregnant women during prenatal care and antiretroviral therapy for HIV infected pregnant women and newborns. With interventions to reduce injection drug use and prevent sharing of syringes, there has been a substantial decrease in HIV transmission associated with injection drug use. These successes argue for the continuation of these strategies to prevent perinatal and IDU-related transmission of HIV.

The demographics of the epidemic have shifted over the past 25 years. The majority of HIV/AIDS cases continue to occur among males. This is particularly true for men who have sex with men who account for approximately 45% of all newly reported HIV/AIDS diagnoses in the U.S. As the number and proportion of cases in males have declined, the proportion of cases in females has increased. Women now make up approximately one quarter of all new HIV/AIDS diagnoses. Racial/ethnic minorities are disproportionately affected by HIV/AIDS and disparities have widened over time. In 2004, estimated U.S. HIV/AIDS case rates for Blacks and Hispanics were 8.5 and 3.3 times higher, respectively, than rates for Whites. Among females, U.S. case rates among Black females were 21 times higher than rates for White females (CDC, 2006b). These shifts in the distribution of HIV/AIDS cases present new and ongoing challenges: how to effectively reach women and heterosexuals at increased risk and how to mobilize racial/ethnic

minority communities to engage with HIV prevention efforts, while continuing to provide effective approaches to risk reduction among men who have sex with men.

Alaska is fortunate in having a relatively low prevalence of HIV/AIDS. Through December 2005, a total of 1,048 cases of HIV or AIDS were reported in the state. This includes persons who were first diagnosed in Alaska and persons who moved to Alaska with an earlier diagnosis of HIV or AIDS. The number of newly diagnosed cases averaged 40 (ranging from 36 to 58) per year over the five year period of 2001 through 2005. Cases of perinatal transmission and pediatric cases (≤ 13 years of age) have been rare in Alaska. Voluntary HIV testing during prenatal care appears to be widely accepted and routinely offered. Alaskans are being tested for HIV at levels comparable to the nation. In 2004, 51% of Alaskans reported ever being tested for HIV aside from testing for blood donation. Of these, 34% report being tested within the previous 12 months. In 2005, 47% of Alaskans reported ever being tested for HIV (State of Alaska, 2006).

The majority of HIV/AIDS cases reported in Alaska continue to occur among males, but the proportion of male cases has decreased over time. Between 1991 and 1995 there was an average of 48 newly diagnosed cases per year in males. Between 2001 and 2005 there was an average of 29 newly diagnosed cases in males each year and males made up 73% of the newly diagnosed cases reported in that time period. HIV cases associated with men who have sex with men (including men with dual risks of sex with men and injection drug use) continue to constitute the majority (56%) of recent cases among men. As is the case nationally, as the number of cases in men has declined over time, the proportion of cases in women has increased. Women made up 17% of newly diagnosed cases in Alaska between 1991 and 1995. In the five year period of 2001 through 2005 women made up 27% of newly diagnosed cases. In the five year period of 1991 to 1995 there was an average of 10 cases in women newly diagnosed per year; in 2001 to 2005 there was an average of 11 cases per year. Heterosexual transmission accounts for 54% of the cases among women in Alaska diagnosed with HIV only (not AIDS) in the period of 2001 to 2005. In Alaska as in the nation, racial/ethnic minority populations are disproportionately affected by HIV/AIDS. Unlike in the Lower 48, Alaska Natives/American Indians have the greatest disparity in HIV cases. This disparity has widened over the last five years, especially for Alaska Native women who make up 28% of the 39 cases of HIV-only diagnosed in women in the five year period of 2001-2005.

While Alaska has been successful in reducing the average number of newly diagnosed HIV cases over the past 15 years, the ultimate goal is to prevent new HIV infections. Alaska faces many of the same challenges to HIV prevention that confront the U.S. as a whole: engaging persons living with HIV in prevention services over the long run; recruiting high risk persons with low perception of risk to testing and prevention counseling; and finding fresh approaches to prevention for behavioral risk populations that may be experiencing HIV prevention fatigue or complacency. With geographic separation from the epicenters of the HIV epidemic, low HIV prevalence, and a widely dispersed and diverse population, Alaska faces ongoing challenges in keeping HIV appropriately in the forefront of health concerns for those at risk and in extending prevention to match the reach of the virus. The *2007-2009 Alaska HIV Prevention Plan* sets out strategies to address these challenges over the three year period of the Plan.

The 2007-2009 Alaska HIV Prevention Plan

The *2007-2009 Alaska HIV Prevention Plan* is the sixth comprehensive plan produced by the Alaska HIV Prevention Planning Group (HPPG) and the State of Alaska HIV/STD Program. This Plan describes the epidemiology of HIV/AIDS in Alaska and related risk factors, the populations at greatest need for HIV prevention interventions, and recommendations for interventions that are most appropriate to meet these needs.

The Plan is designed to provide guidance for HIV prevention activities in all sectors and areas of Alaska for the next three years. It is intended to guide specific interventions for those at greatest risk of HIV infection; to generate community discussion and input; to encourage collaboration among individuals, organizations, and community groups providing HIV prevention and care; and to encourage integration of HIV prevention interventions into other services for people likely to engage in risk behaviors – all with the goal of preventing HIV and AIDS in Alaska.

This Plan considers epidemiologic data, HIV prevention needs, resources and service gaps for the most affected populations, and the published research on, and program experience with, HIV prevention interventions. The resulting recommendations in the Plan are based on scientific evidence, local experience, and community values. The Plan guides the health department's annual application to Centers for Disease Control and Prevention (CDC) for federal HIV prevention funds. With these and other funds, the State HIV/STD Program and its grantees and contractors carry out the nine essential components of the HIV prevention program for Alaska.

Comprehensive HIV Prevention Program Components

The State of Alaska HIV/STD Program receives funding for HIV Prevention activities from the CDC. CDC defines a comprehensive HIV prevention program as including the following nine essential components:

1. HIV prevention community planning;
2. HIV prevention activities;
 - a. HIV counseling, testing and referral services (CTR);
 - b. Partner counseling and referral services (PCRS) with strong linkages to prevention and care services;
 - c. Prevention for HIV-infected persons;
 - d. Health education and risk reduction (HE/RR) activities;
 - e. Public information programs (if addressed in the jurisdiction's Prevention Plan);
 - f. Perinatal transmission prevention (for jurisdictions with ≥ 150 perinatal HIV cases);
3. Quality assurance;
4. Evaluation of major program activities, interventions, and services, as well as collection of data on interventions and clients served;
5. Capacity-building activities;
6. Sexually transmitted disease prevention activities;
7. Collaboration and coordination with other related programs;
8. Laboratory support; and

9. HIV/AIDS epidemiologic and behavioral surveillance.

The *2007-2009 Alaska HIV Prevention Plan* is the culmination of the HIV prevention community planning work of the Alaska HPPG in 2005 and 2006 (component #1). The recommendations in the Plan guide the health department's implementation of the HIV prevention activities in Alaska (components #2a through e; f does not apply to Alaska). The HIV/STD Program and collaborating divisions of the Alaska Department of Health and Social Services carry out or facilitate the remaining required components of the state's comprehensive HIV prevention program.

Advancing HIV Prevention Initiative

In 2003, the Centers for Disease Control and Prevention launched the *Advancing HIV Prevention Initiative* (CDC, 2003) with the goal of reducing the number of new infections in the U.S. by increasing the number of persons who know their HIV status and connecting persons with HIV to care and prevention services. The initiative proposed four strategies:

- Making HIV screening a routine part of medical care;
- Implementing new models for diagnosing HIV infection, including the use of rapid testing;
- Improving and expanding prevention services for people living with HIV/AIDS; and
- Further decreasing perinatal HIV transmission through routine, voluntary HIV testing during prenatal care.

The *2007-2009 Alaska HIV Prevention Plan* incorporates AHP strategies that are applicable to a state with low HIV prevalence. In addition, the Plan proposes strategies to raise community awareness of risk and acceptance of risk reduction, and to reduce risk behaviors in HIV-negative individuals at high risk of HIV infection.

Organization of the 2007-2009 Alaska HIV Prevention Plan

The *2007-2009 Alaska HIV Prevention Plan* includes priority populations and a set of recommended interventions for each population. Populations are selected and prevention interventions are chosen so as to maximize the public health impact of the available prevention resources in order to prevent as many new infections as possible. Key information that was used to develop the comprehensive HIV prevention plan is found in the epidemiologic profile (Chapter 2) and the community services assessment (Chapter 3). The Plan is organized to incorporate the key products of a comprehensive plan as outlined in CDC's *2003-2008 HIV Prevention Community Planning Guidance*.

Chapter One offers an **Introduction** to HIV prevention successes and current challenges, components of an HIV prevention program, the national Advancing HIV Prevention Initiative, and an overview of the *2007-2009 Alaska HIV Prevention Plan*.

Chapter Two contains the **Epidemiologic Profile**, which describes the impact of the HIV epidemic in Alaska and other surrogate markers for HIV risk behaviors (e.g., sexually transmitted disease, teen pregnancy rates, information on drug use, and results of behavioral risk factors surveys in Alaska).

Chapter Three describes the **Community Services Assessment**, which provides information on the prevention needs of populations at risk for HIV infection, the prevention activities/interventions implemented to address these needs, and service gaps.

Chapter Four encapsulates the rationale for selecting the **Priority Populations** for 2007-2009. This chapter focuses on a set of populations identified for prevention efforts due to the impact of HIV infection in these populations and the prevalence of other risk factors.

Chapter Five focuses on **Interventions** that have undergone scientific evaluation and have demonstrated effectiveness in helping people make behavior changes to reduce their risk of HIV infection. The Alaska HIV Prevention Planning Group (HPPG) and the State of Alaska HIV/STD Program drew upon local experience, and knowledge of cultural/ethnic appropriateness, to select from among these interventions those likely to best meet the HIV prevention needs of each of the priority populations.

Chapter Six presents the **Recommendations** of the Alaska HIV Prevention Planning Group (HPPG) for prevention activities statewide and for interventions specific to each priority population. This chapter also describes activities to be carried out by the health department in the areas of quality assurance, evaluation, capacity building, and other elements of a comprehensive HIV prevention program.

Chapter Seven is an **Overview of the Community Planning Process**. This chapter discusses the Alaska HPPG and their major goals and guidelines set by the CDC, as well as community input processes.

Chapter 2

Epidemiologic Profile



2007-2009 Alaska HIV Prevention Plan

Chapter Two: Epidemiologic Profile Summary

This chapter presents a brief summary of the Epidemiologic Profile on HIV/AIDS in Alaska included in Appendix A.

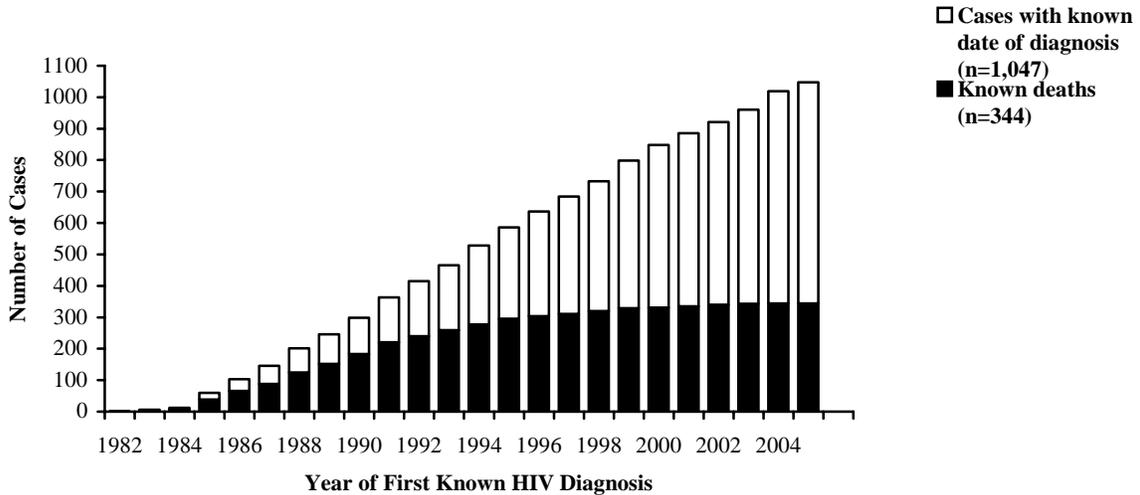
The first case of AIDS was reported in Alaska in 1982, before the human immunodeficiency virus had been recognized as the cause of AIDS and before a laboratory test to detect antibodies to HIV had been developed. By December 31, 2005, a total of 1,048 cases of HIV, with and without AIDS, had been reported in Alaska. Data presenting characteristics of these cases follow, and should be interpreted in the context of cumulative scientific knowledge about HIV/AIDS.

Table 1. Cumulative HIV and AIDS Cases Reported to the Alaska Division of Public Health through December 31, 2005 N=1,048

	Total HIV & AIDS Cases Reported In Alaska	HIV & AIDS Cases Not Known to Have Died	HIV & AIDS Cases Known to Have Died
HIV Cases with AIDS	730	411	319
HIV Cases without AIDS	318	293	25
Total Reported HIV/AIDS Cases	1,048	704	344

The cumulative total of HIV cases (with and without AIDS) and known deaths due to any cause are shown in Figure 1. In this graph, a death in a person with HIV is shown in the year the case was first diagnosed (rather than the year in which the death actually occurred) to better illustrate case mortality.

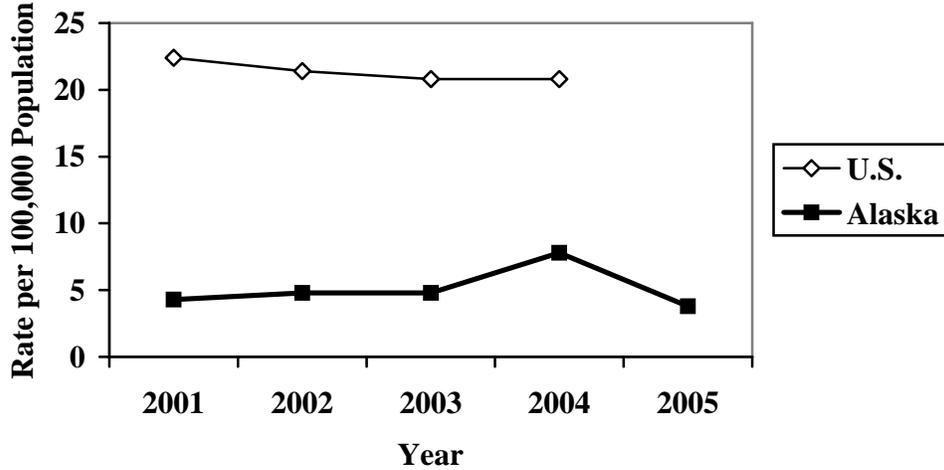
Figure 1. Cumulative HIV Cases and Known Deaths by Year of First Known HIV Diagnosis through December 31, 2005, Alaska N=1,048 (1 case with unknown date of diagnosis is not included below)



On average, 40 HIV/AIDS cases were newly diagnosed per year in Alaska from 2001-2005, a decline from the average of 52 cases per year in the period from 1996-2000 (Table 2). Beginning in 1996, the number of HIV-related deaths per year declined significantly in Alaska as well as in the U.S., primarily due to advances in medical care and the development of antiretroviral medications. The decline in deaths, combined with ongoing occurrence of new infections, resulted in a steady increase in the number of persons living with HIV (Figure 1). Needs for medical care, supportive services, and ongoing prevention services will continue to grow as persons with HIV live longer, healthier lives.

Rates of occurrence of HIV/AIDS from 2001-2005 (HIV incidence) in Alaska and the U.S. are presented below in Figure 2. HIV incidence rates in Alaska during this period were considerably lower than those in the U.S. as a whole. In this graph, Alaska HIV cases are defined as cases reported in individuals who were Alaska residents at their first known date of HIV/AIDS diagnosis. Case rates are expressed per 100,000 population.

Figure 2. HIV Incidence (with and without AIDS) 2001-2005, Alaska* and U.S.**



*Alaska cases include only those with first known HIV/AIDS diagnosis while an Alaska resident

**Estimated U.S. rates were calculated from CDC data on HIV/AIDS incidence for the 33 states, plus Guam and the Virgin Islands, with confidential HIV reporting since 2000, as published in the *HIV/AIDS Surveillance Report, 2004*, Vol. 16, Table 5b

Gender

Since the time the earliest HIV/AIDS cases were identified in Alaska, the number and proportion of HIV/AIDS cases in males exceeded those in females. This was true throughout the U.S.

Females - Of 1,048 cumulative HIV cases reported in Alaska through 2005, 202 cases (19%) were in females. The average number of HIV cases per year among females in Alaska increased in periods beginning in 1982 through 2000 (from an average of 1 case per year to an average of 14 cases per year), then decreased for the period from 2001-2005 (to an average of 11 cases per year). The proportion of total cases occurring in females increased steadily over time, from 8% to 27%. In recent periods this proportionate increase was due primarily to a decline in the number and proportion of cases in males (Table 2).

Males - Of 1,048 cumulative Alaska HIV cases, 846 cases (81%) were in males. The average number of HIV/AIDS cases per year newly diagnosed in males decreased in time periods after 1990 (Table 2).

Table 2. Average Number of HIV/AIDS Cases Newly Diagnosed per Year by Gender, Time Periods from 1982-2005, Alaska N=1,048 (one case with unknown year of diagnosis is not included in the table)

Time Period	Average Number of HIV/AIDS Cases Newly Diagnosed Per Year				
	Males		Females		Average Total Number of HIV/AIDS Cases Per Year in Time Period, Males & Females**
	Average Number of Male Cases Per Year	Proportion of Male Cases in Total HIV/AIDS Cases During Time Period	Average Number of Female Cases Per Year	Proportion of Female Cases in Total HIV/AIDS Cases During Time Period	
1982-1985*	14	92%	1	8%	15
1986-1990	43	90%	5	10%	48
1991-1995	48	83%	10	17%	57
1996-2000	38	73%	14	27%	52
2001-2005	29	73%	11	27%	40

*First AIDS case diagnosed in Alaska in 1982

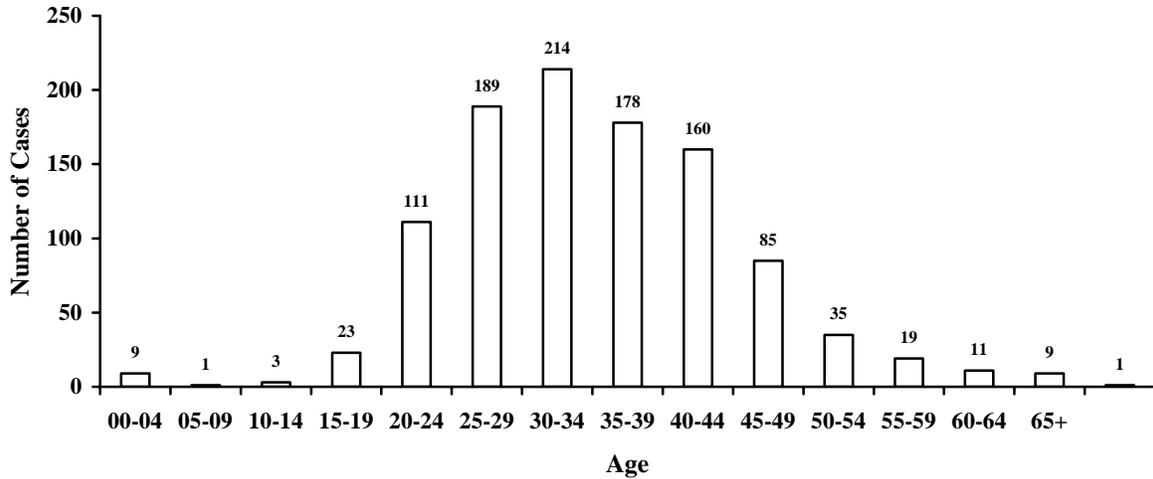
**Due to rounding, the sum of the average number of cases for males and the average for females may not always equal the average total number of male and female cases (e.g., in 1991-1995, the average total number of cases per year is actually 57 rather than 48+10=58)

Although the average annual number of new cases from 2001-2005 was the smallest since 1982-1985, it shows continued incidence of new HIV infection.

Age

Of total cumulative HIV cases reported in Alaska, the largest number (214; 20% of the total) was in persons aged 30-34 years at initial HIV diagnosis. Overall, 741 (71%) HIV cases occurred in individuals who were between the ages of 25-44 years at the time of their initial HIV diagnosis. Unlike some other areas of the U.S., relatively few HIV cases were reported among very young people in Alaska: 13 (1%) of 1,048 cases were aged 0-14, 23 (2%) were aged 15-19, and 111 (11%) were aged 20-24 years at time of initial HIV diagnosis (Figure 3).

Figure 3. Cumulative HIV Cases through December 31, 2005 (with and without AIDS) by Age at First Known HIV Diagnosis, Alaska N=1,048 (1 case with unknown age not shown below)

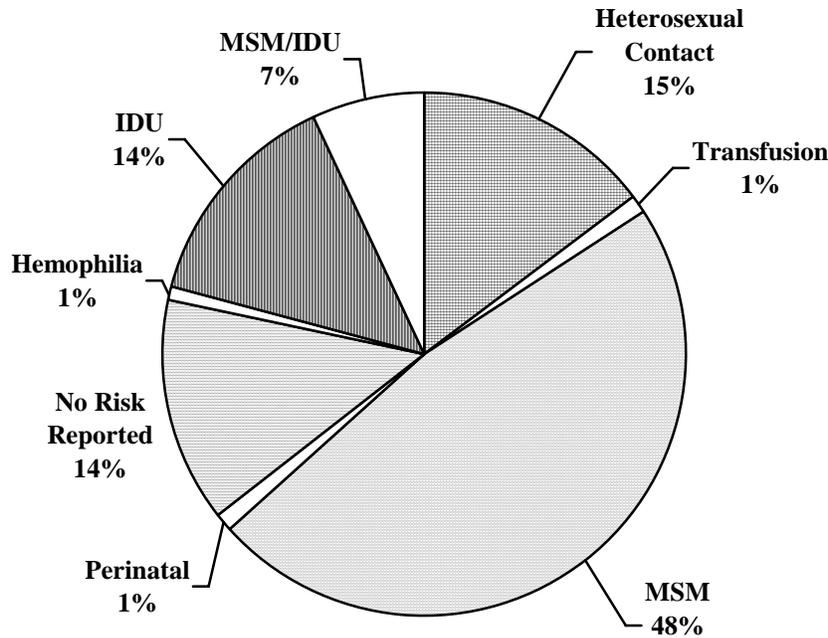


Transmission Category

In order to have consistent national data comparable across all areas, HIV/AIDS cases are categorized according to specific national definitions in a hierarchy the CDC has established to identify the risk factor most likely to have been responsible for transmission.

Male-to-male sexual contact (MSM) represented, by far, the largest single risk for infection both for the total population of persons reported with HIV infection in Alaska through December 31, 2005 (48% of all cumulative cases) and for males only (59% of male cases). Injection drug use (IDU) as a single transmission category accounted for 14% of cumulative HIV cases (12% of cases in males and 22% of cases in females). HIV cases with both MSM and IDU risks accounted for an additional 7% of total cases. Heterosexual contact to a person at increased risk for HIV (for example, a known HIV-positive, an IDU, or, for females, a bisexual male) accounted for 15% of total cumulative cases (6% of cases in males and 51% of cases in females). The proportions of total cumulative HIV cases related to perinatal transmission, transfusion or transplantation, or receipt of blood products for hemophilia were low at 1%, each. (Figure 4)

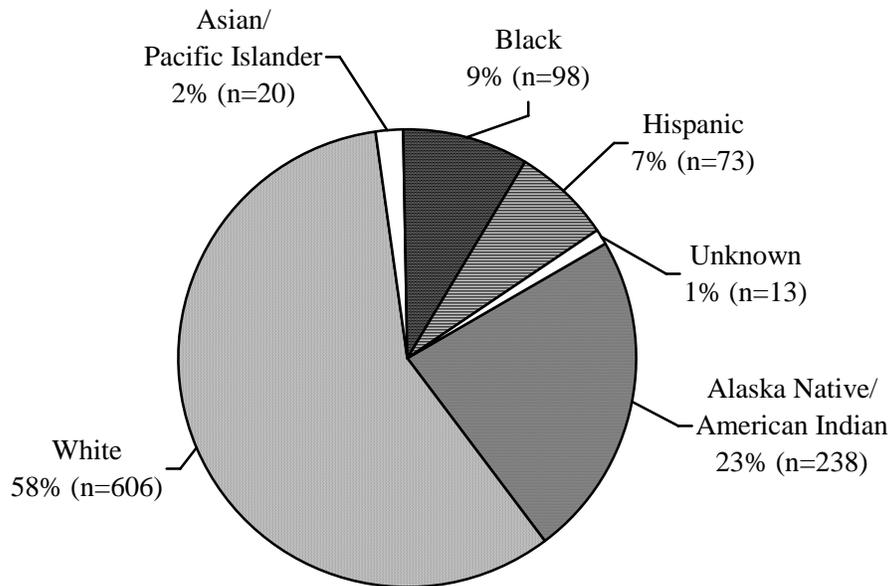
Figure 4. Cumulative HIV Cases (with and without AIDS) by Transmission Category through December 31, 2005, Alaska (N=1,048)



Race/Ethnicity

HIV affected individuals in all racial and ethnic groups in Alaska. Although individuals are not at risk of HIV infection due to their race/ethnicity, it is sometimes an indicator of economic and social factors that may influence risk of exposure to HIV. Of the 1,048 cases reported through 12/31/05, 606 (58%) were in Whites, 238 (23%) in Alaska Natives/American Indians, 98 (9%) in Blacks, 73 (7%) in Hispanics, 20 (2%) in Asian/Pacific Islanders, and 13 (1%) were of unknown race/ethnicity. Data on race/ethnicity for all cumulative HIV cases are presented in Figure 5.

Figure 5. Cumulative HIV Cases (with and without AIDS) by Race/Ethnicity through December 31, 2005, Alaska N=1,048



Data on HIV/AIDS by gender and race/ethnicity are presented in Tables 3 and 4 for males and females 15 years of age or older, as are Alaska population estimates. This age range was selected to make the data more comparable across racial/ethnic groups. Few HIV cases occur in individuals younger than 15 years, but the number of individuals in the population that are younger than 15 years of age is large and unevenly distributed across the different racial/ethnic groups. Data are presented separately for males and females because the proportions of females and males differ across racial/ethnic groups. Please note that the HIV *case* data classify individuals of Hispanic ethnicity as a separate racial/ethnic category while the Alaska *population* data include individuals of Hispanic ethnicity within the four race categories. Population data for individuals of Hispanic ethnicity are also separately shown in brackets [] in Tables 3 and 4.

Table 3. Cumulative HIV Cases (with and without AIDS) in Males Aged 15 Years and Older at First HIV Diagnosis, by Race/Ethnicity through December 31, 2005, and 2005 Alaska Male Population Aged 15 Years and Older

Race/Ethnicity	HIV Cases First Diagnosed in Males \geq 15 Years of Age		Males \geq 15 Years of Age, Alaska Population*	
	Number	% Total	Number	% Total
White	511	61%	195,927	76%
Alaska Native/American Indian	168	20%	40,709	16%
Black	70	8%	9,772	4%
Asian/Pacific Islander	15	2%	11,890	5%
Hispanic Ethnicity	62	7%	[8,817]**	[3%]**
Unknown Race	10	1%	---	---
Total	836	100%	258,298	100%

* Population data are from the Alaska Department of Labor and Workforce Development's Alaska State Race Bridged Smooth Series estimates for July 1, 2005

**Males \geq 15 years of Hispanic/Latino ethnicity are included within the four race categories in the Alaska population data, as well as shown as a separate group

Table 4. Cumulative HIV Cases (with and without AIDS) in Females Aged 15 Years and Older at First HIV Diagnosis, by Race/Ethnicity through December 31, 2005, and 2005 Alaska Female Population Aged 15 Years and Older

Race/Ethnicity	HIV Cases first Diagnosed in Females \geq 15 Years of Age		Females \geq 15 Years of Age, Alaska Population*	
	Number	% Total	Number	% Total
White	87	44%	180,991	74%
Alaska Native/American Indian	67	34%	40,826	17%
Black	26	13%	9,241	4%
Asian/Pacific Islander	5	3%	14,056	6%
Hispanic Ethnicity	10	5%	[8,662]**	[4%]**
Unknown Race	3	2%	---	---
Total	198	100%	245,114	100%

* Population data are from the Alaska Department of Labor and Workforce Development's Alaska State Race Bridged Smooth Series estimates for July 1, 2005

**Females \geq 15 years of Hispanic/Latino ethnicity are included within the four race categories in the Alaska population data, as well as shown as a separate group

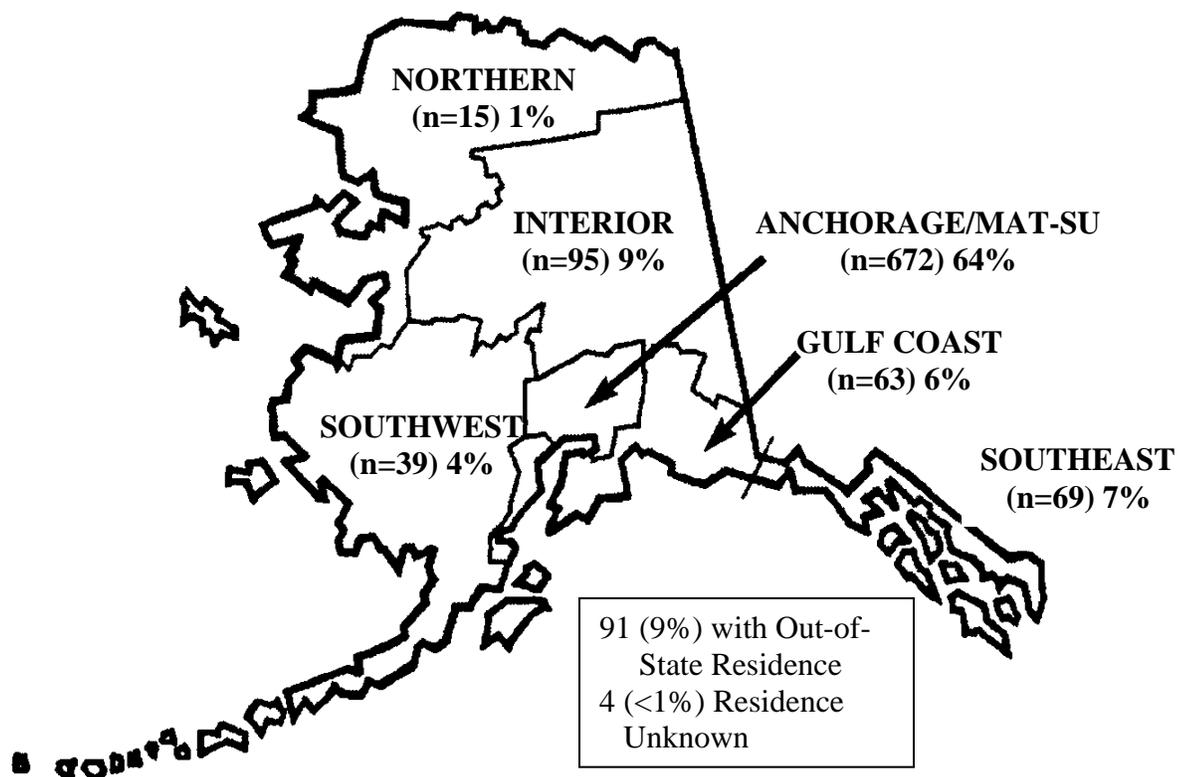
Compared to their distributions in the overall Alaska population, Alaska Native/American Indian, Black, and Hispanic males were over-represented, and White and Asian/Pacific Islander males were under-represented, among cumulative cases of HIV infection in adult/adolescent males. Compared to their distributions in the overall Alaska population, Alaska Native/American Indian, Black, Asian/Pacific Islander, and Hispanic females were over-represented, and White females were under-represented, among cumulative cases of HIV infection in adult/adolescent females.

Geographic Region of Residence at First HIV Diagnosis in Alaska

HIV cases were reported from all regions of the state. At the time of their first HIV diagnosis in Alaska, 672 cases (64%) reported a residence of Anchorage/Mat Su, the most populous region of the state (53% of the state population resided in the Anchorage/Mat Su region in 2005). A total of 747 HIV cases (71%) resided in the urban areas of Anchorage, Fairbanks or Juneau (60% of the state's 2005 population) at the time of their first HIV/AIDS diagnosis in Alaska.

People with HIV infection may have no noticeable symptoms for years after initial infection and may not seek medical care leading to a diagnosis for an extended period. Additionally, many individuals are highly mobile. The following data must therefore be interpreted with caution. An individual's residence at the time he or she was first diagnosed with HIV infection is not necessarily the area where infection initially occurred or the area where the infected individual currently resides or seeks care, if still living.

Figure 6. Region of Residence* at Time of First HIV/AIDS Diagnosis in Alaska, Cumulative Cases Reported through December 31, 2005, Alaska N=1,048



*Note: Region of residence is defined as region of residence at first HIV diagnosis, when known, the region of residence at first AIDS diagnosis when the residence at HIV diagnosis is unknown, and the region of first case report when residence at HIV and AIDS diagnosis are unknown

HIV Cases Presumed to be Living

Of the 1,048 HIV/AIDS reported through December 31, 2005, 704 were not known to have died. Data presented below assumed all of these cases were still living, although that is unlikely (some undoubtedly moved and died while residents of another state). Characteristics of persons living with HIV/AIDS (PLWHIV) in Alaska were similar to those of persons living with HIV/AIDS in the U.S., with the exception of race/ethnicity. The data on transmission categories are difficult to compare because CDC's estimated U.S. data statistically redistribute cases with "no risk identified" into the other transmission categories, while cases in this category are shown separately in the Alaska data.

- Of all PLWHIV, 78% of cases reported in Alaska were male, and 73% of U.S. adult/adolescent cases were male.
- The largest single proportion of PLWHIV in Alaska and in the U.S. was in the age group of 40-44 years (22% for each).
- Of male PLWHIV, 56% of Alaska and 60% of U.S. cases were in MSM; 14% of Alaska and 19% of U.S. cases were in IDU; 7% of Alaska and 13% of U.S. cases were exposed through heterosexual contact; and 8% of Alaska and 7% of U.S. cases were in MSM who also were IDU.
- Of female PLWHIV, 55% of Alaska and 71% of U.S. PLWHIV were exposed through heterosexual contact; and 18% of Alaska and 27% of U.S. PLWHIV were exposed through IDU.
- The proportions of the Alaska population by race differ from those of the U.S., and proportions of PLWHIV likewise differ: 58% of Alaska and 34% of U.S. PLWHIV were White; 23% of Alaska and less than 1% of U.S. PLWHIV were Alaska Native/American Indian; 9% of Alaska and 48% of U.S. PLWHIV were Black; 7% of Alaska and 17% of U.S. PLWHIV were Hispanic; and 2% of Alaska and less than 1% of U.S. PLWHIV were Asian/Pacific Islander.

HIV Cases with Recent and Earlier HIV Infections

Characteristics of cases infected with HIV more recently may differ from those infected in years past, potentially indicating changes in populations at risk over time. In order to allow for comparison, given the small case numbers in Alaska, data on HIV infections that were first diagnosed from 2001-2005 and had not progressed to AIDS were selected as indicators of "recent" HIV infections. Cases infected "earlier" were represented by all cases of HIV without AIDS diagnosed prior to 2001 and all cases of HIV with AIDS.

Of the 1,048 HIV cases reported through December 31, 2005, 118 met the definition of recent cases (cases diagnosed between 2001-2005 without progression to AIDS). Of these 118 recent HIV cases, 79 (67%) were in males and 39 (33%) were in females. Of 930 earlier HIV/AIDS cases, 767 (82%) were in males and 163 (18%) were in females. The proportion of males (67%) was slightly less, and the proportion of females slightly greater (33%) among recent cases reported in Alaska than in 2004 cases reported in the 42 U.S. areas with confidential name-based HIV reporting (70% among males and 30% among females). Recent cases in males in Alaska

were slightly older than earlier male cases while the age distribution of recent female cases in Alaska was similar to that of earlier cases.

Transmission risk for the greatest proportion of recent and earlier cases in males was male-to-male sexual contact, but the proportion was smaller for recent (53%) as compared to earlier (60%) cases. Transmission risk for the greatest proportion of recent and earlier cases in females was heterosexual contact to a person with or at increased risk for HIV, and the proportion was greater for recent (54%) than for earlier (51%) cases.

A majority of all recent and earlier HIV cases had a residence of Anchorage/Mat-Su at the time of first HIV diagnosis in Alaska, although the proportion with this residence was smaller in recent cases (54%) than in earlier cases (65%).

HIV Testing in Alaska

In 2005, 47% of Alaskans aged 18-64 years reported ever having had an HIV test, as compared to 38% of the U.S. population. The percentage of persons who report ever being tested has consistently been slightly higher in Alaska than in the U.S. (These data were drawn from the annual Behavioral Risk Surveillance System in Alaska and nationwide.)

Prenatal testing reaches many Alaska women of childbearing age. In 2003, 80% of women delivering live infants in Alaska recalled their provider discussing prenatal HIV testing with them, and were likely to have received HIV screening as part of their prenatal care. This proportion is consistent with those in earlier years (ranging from 76%-82% between 1999-2002). There were 48,542 births in Alaska from 1999-2003. (These data were drawn from the annual Alaska Pregnancy Risk Assessment Monitoring Survey.)

Of 12,291 individuals tested for HIV in 2005 through the State Virology Laboratory, 11 (0.09%) were HIV positive.

Identifying HIV Infection Early in the Course of Disease

From 2001-2005, 36% of individuals with Alaska residence at the time of their initial HIV diagnosis developed AIDS within 12 months of their initial HIV diagnosis. This likely indicates diagnosis late in the course of their HIV disease. Comparable data for the U.S. show that of all HIV infections diagnosed in 2003, 39% progressed to AIDS within 12 months after HIV infection was diagnosed.

Although a number of individuals with HIV are presumed to be unaware of their infection, HIV screening of the general population in Alaska has not been very effective in identifying people with previously undiagnosed HIV infection. Different models of targeted outreach associated with testing, some using rapid HIV tests, are being explored to identify ways to best reach those at risk. Partner notification activities, working with persons diagnosed with HIV to contact and offer HIV testing to their sexual and needle-sharing partners, remain the most effective means of

reaching persons at highest risk prior to symptomatic disease. From 2003-2005, partner notification activities identified 37% of all cases of HIV newly diagnosed in Alaska.

STD as Indicators of HIV Risk

Sexually transmitted diseases/infections (STD) indicate unprotected sex and potential risk for HIV infection. Individuals with STD are at increased risk of acquiring HIV, if exposed through unprotected sex, or of transmitting HIV sexually if they have HIV infection. A total of 4,357 cases of chlamydia and 601 cases of gonorrhea were reported in Alaska in 2005, and the chlamydia infection rate in Alaska was one of the highest in the U.S. Fortunately, HIV infection occurred much less frequently, and relatively few individuals ever reported with chlamydia or gonorrhea infections were ever reported with HIV through December 31, 2005. The number of infectious syphilis cases in Alaska, although small in 2004-2005, was the greatest it had been for many years. In contrast to the situation with gonorrhea or chlamydia, 30% of the 26 persons identified with infectious syphilis in 2004-2005 had HIV infection or had a recent HIV exposure.

Chapter 3

Community Services Assessment



2007-2009 Alaska HIV Prevention Plan

Chapter Three: Community Services Assessment

A Community Services Assessment (CSA) is a description of the prevention needs of populations at risk for HIV infection, the prevention services available to address these needs, and service gaps. The HIV Community Planning Guide defines the three elements of a CSA as:

- Needs Assessment – information on the current status and service needs of a defined population or geographic area. Needs that may be identified include indications of risk behaviors, service utilization and barriers to services.
- Resource Inventory – current HIV prevention and related resources and activities including information regarding HIV prevention activities and other education and prevention activities, regardless of funding source, that are likely to contribute to HIV risk reduction.
- Gap analysis – a description of the unmet HIV prevention needs within the high-risk populations defined in the epidemiologic profile.

Development of the Comprehensive Prevention Plan involves comparing needs against the activities and services available to meet those needs, and the funding sources of those activities and services, in order to project what service gaps would exist in the 2007 to 2009 period and therefore should to be addressed in recommendations in the Plan.

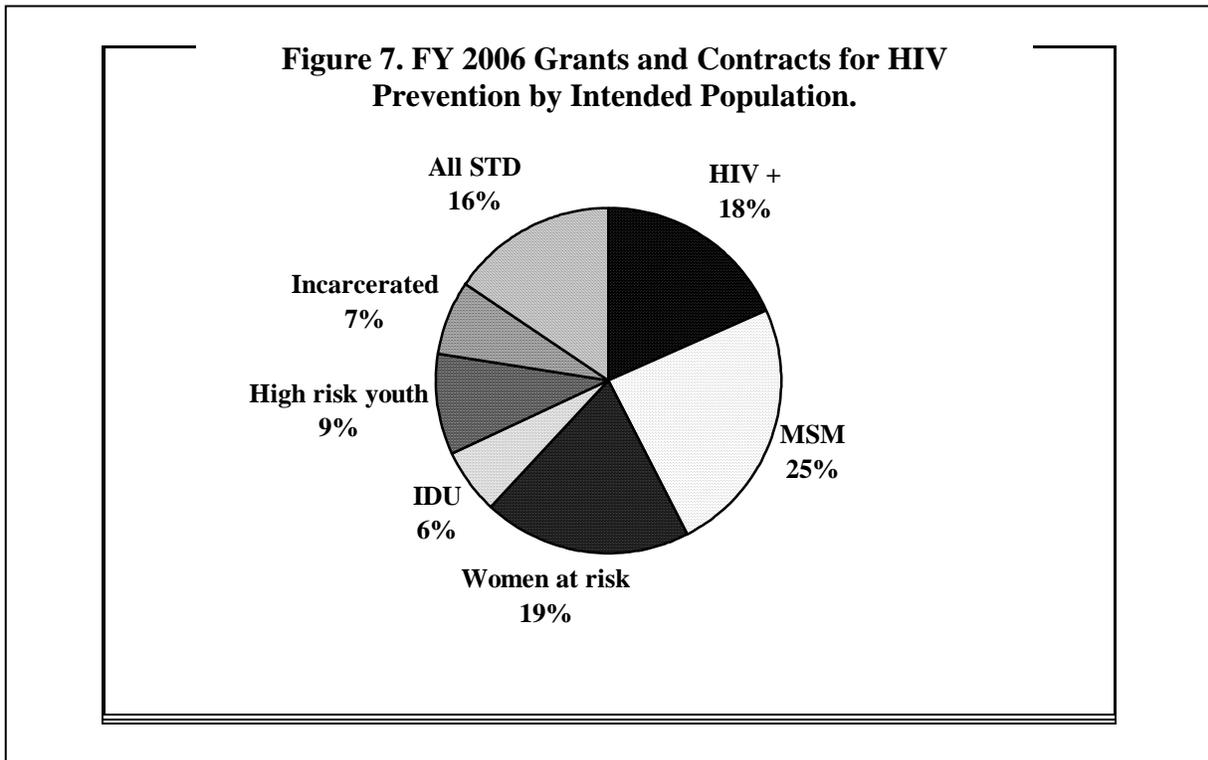
Funding for HIV Prevention in Alaska

There are four main funding sources for HIV prevention in Alaska:

- (1) *State HIV prevention grants and contracts using federal funds from the CDC HIV Prevention Cooperative Agreement* are administered by the HIV/STD Program, awarded on a competitive basis, and are usually funded on a three year cycle with annual review and renewal. The current grant cycle is through the end of the State fiscal year 2007 (June 30, 2007). The next grant cycle will be July 1, 2007 through June 30, 2010.
- (2) *HIV-specific Services Directly Funded by Federal Agencies* refer to HIV prevention or care programs funded directly to an agency or organization by a federal agency such as the CDC or the Health Resources and Services Administration (HRSA) which funds Ryan White CARE grants and Special Projects of National Significance (SPNS) for research on HIV prevention and care services.
- (3) *State-funded Services* refer to prevention related activities that are incorporated into programs of state agencies, but that are not funded specifically for HIV prevention under the CDC HIV prevention cooperative agreement, such as substance abuse treatment programs, Department of Corrections programming for inmates, and most Public Health Center services.
- (4) *Non-public Funding Sources* refer to private foundations and fund raising activities by community-based organizations. Non-publicly funded HIV prevention services are very limited in Alaska.

The State of Alaska receives federal funds for HIV prevention from the Centers for Disease Control and Prevention. The period of the current cooperative agreement with CDC is January 1, 2004 through December 31, 2008. In 2006, the annual award was \$1,417,619. With annual

rescissions by CDC, this represents a decrease of 4.4% over the last three years. The State does not anticipate any increase in federal funding over the next three years and additional rescissions and increasing costs may further erode resources for HIV prevention. No State general funds are specifically allocated for HIV prevention at the present time. Of the \$1.4 million in HIV prevention funds, 47% goes to grants and contracts for prevention interventions for the priority populations identified in the *2004-2006 Alaska HIV Prevention Plan*; approximately 13% goes to HIV partner services and HIV counseling and testing provided by State public health personnel; and 40% covers program administration, planning and evaluation. In state fiscal year 2006, of the 47% in grants and contracts, 18% were allocated to prevention activities for HIV positive persons; 25% for prevention programs for men who have sex with men, 19% for women at increased risk, especially women in race/ethnic groups that are overrepresented in the HIV cases in Alaska; 6% for injection drug users; 9% for high risk youth, and 7% for incarcerated persons in community residential centers (halfway houses). An additional 16% of prevention funds were allocated for STD partner services for persons diagnosed with a reportable STD (Chlamydia, gonorrhea, or syphilis) and their sex partners.



Grants and contracts are awarded on a competitive basis for a three year period with annual review and renewal. The 2005 through 2007 grant cycle will end June 30, 2007. Thus, the needs now met by the HIV prevention services currently funded through the State to community organizations will become unmet needs in mid-2007. The Alaska HIV Prevention Planning Group had this funding cycle in mind when assessing unmet needs for the period covered by the

new plan starting January 2007. In early 2007, the State will issue a new request for proposals (RFP) for HIV prevention. The RFP will solicit applications for HIV prevention programs for the priority populations and interventions recommended in the *2007 to 2009 Alaska HIV Prevention Plan*. Grant awards to successful applicants responding to the RFP will determine the State-funded interventions to be carried out by community organizations for the period July 1, 2007 through June 30, 2010.

HIV Prevention Resources in 2006 by Agency

Table 5 describes the HIV prevention interventions conducted by community organizations under grants or contracts with the State of Alaska awarded for the three year period of July 1, 2004 through June 30, 2007.

Table 5. State-funded HIV Prevention Interventions by Agency July 1, 2004 through June 30, 2007			
Agency	Target Population	Intervention Model	Intervention Type(s)
Alaskan AIDS Assistance Association (Four A's)	HIV-Positive Persons	<i>Healthy Relationships</i>	▪ Group HE/RR Multi-Session
		CD4 Group	▪ Group HE/RR Single Session
	Men Who Have Sex With Men	<i>MPowerment</i>	▪ Outreach ▪ Social Marketing ▪ Group HE/RR Single Session
	Ethnic Minority Women	<i>Real AIDS Prevention Project (RAPP)</i>	▪ Outreach ▪ Social Marketing ▪ Group HE/RR Single Session
		Juneau Outreach	▪ Outreach
	Incarcerated Individuals	Incarcerated Groups in Anchorage & Juneau	▪ Group HE/RR Single Session
Alaska Native Tribal Health Consortium (ANTHC)	Men Who Have Sex With Men	<i>MPowerment</i>	▪ Outreach ▪ Social Marketing ▪ Group HE/RR Single Session
		<i>Popular Opinion Leader</i>	▪ Outreach
Alaska Youth and Parent Foundation (AYPF)	Youth at Increased Risk	Targeted Outreach	▪ Peer Outreach
		Peer-led Groups	▪ Group HE/RR Single Session
		<i>Making Proud Choices</i>	▪ Group HE/RR Multi Session
Anchorage Neighborhood	HIV-Positive Persons	<i>Prevention Case Management</i>	▪ Prevention Case Management

Table 5. State-funded HIV Prevention Interventions by Agency July 1, 2004 through June 30, 2007			
Agency	Target Population	Intervention Model	Intervention Type(s)
Health Clinic (ANHC)		Risk Reduction Counseling in a Medical Care Setting	▪ Individual HE/RR
	Ethnic Minority Women	<i>Partners in Prevention</i>	▪ Group HE/RR Multi Session
Anchorage School District	Youth	<i>RARE-T</i>	▪ Peer Education
Interior AIDS Association (IAA)	Ethnic Minority Women	Targeted Outreach	▪ Outreach
		<i>Partners in Prevention</i>	▪ Group HE/RR Multi Session
	Injection Drug Users	Targeted Outreach	▪ Outreach
		<i>Safety Counts</i>	▪ Group HE/RR Multi Session ▪ Social Event/Outreach ▪ Individual HE/RR
Youth at Increased Risk	<i>Making Proud Choices</i>	▪ Group HE/RR Multi-Session	
Municipality of Anchorage Reproductive Health Clinic (MOARHC)	Men Who Have Sex With Men	HIV Counseling and Testing	▪ HIV Counseling and Testing in Community Settings
	Ethnic Minority Women	HIV Counseling and Testing	▪ HIV Counseling and Testing in Community Settings
	Incarcerated Persons	HIV Counseling and Testing	▪ HIV Counseling and Testing in Community Release Centers
	Partners of STD patients	Partner Services/Disease Intervention	▪ HIV/STD Partner Services

The following summary describes additional resources for HIV prevention in Alaska that are funded for some part of the 2007 to 2009 period covered by the HIV Prevention Plan. These include federally funded projects primarily for HIV prevention as well as federal and state funded programs that address risk factors associated with HIV such as substance abuse or sexual activity and that incorporate an HIV prevention component into their client services. These sources of federal funding have varying funding cycles and duration. Most grants in place in 2006 end in mid-2007 (see Table 5). Notable exceptions are the funding for “Let’s Talk”, an abstinence only curriculum for middle school students funded through September 2008, and the Alaska Native Tribal Health Consortium’s adaptation of the Community Promise model directly funded by CDC for HIV prevention in Bethel and surrounding villages funded through mid-2009.

Alaska Native Tribal Health Consortium (ANTHC)

Funding Source: HRSA Special Projects of National Significance (SPNS)

Funding Cycle: July 1, 2002 through June 30, 2007

Amount: \$200,000 annually

Project Contact: Sherry Trigg 907 729-3951

Project Description:

The purpose of this project is to provide capacity building assistance to Norton Sound Health Corporation (including Nome and 15 villages) to conduct risk reduction counseling and HIV counseling and testing (HIVCT). In addition, this project has conducted community education presentations to increase HIV awareness and generate interest in testing. The project has facilitated training for NSHC Behavioral Health Providers in Nome and villages to conduct risk assessment and risk reduction counseling with clients and then refer them to the hospital lab for serologic HIV testing.

Alaska Native Tribal Health Consortium (ANTHC)

Funding Source: CDC direct funding to Community Based Organizations

Funding Cycle: July 1, 2004 through June 30, 2009

Amount: \$355,197 annually

Project Contact: Michael Covone 907 729-3646

Project Description:

The goal of the project is to increase HIV testing by increasing risk perception and directing persons to testing services. The project is an adaptation of the Community Promise intervention model with the addition of community readiness assessments to gauge community knowledge and attitudes regarding HIV prevention. The project was initiated in Bethel and may expand to selected Yukon-Kuskokwim regional villages. They are implementing outreach in Bethel using role model stories to promote HIV testing, and developing the capacity of Yukon-Kuskokwim Health Corporation village behavioral health paraprofessionals to act as HIV prevention resources.

Yukon Kuskokwim Health Corporation (YKHC) Circle of Care Project

Funding Source: HRSA Special Projects of National Significance (SPNS)

Funding Cycle: July 1, 2002 through June 30, 2007

Funding: \$200,000 annually

Project Contact: Carl Evans 907 543-6486

Project Description:

The first goal of the Circle of Care is to increase the number of individuals living in the Yukon-Kuskokwim Delta who know their HIV status. The second goal is to train health care workers to increase knowledge and skill level. The third goal involves community education about HIV/AIDS issues that influence wellness. This project conducts community education presentations and HIVCT (with risk reduction counseling) using the OraQuick™ HIV rapid test in Bethel and self-selected villages in the YK region. Four villages participate in the research component of the grant looking at the effect of community education on the use of HIV testing. Seven additional villages have received community presentations. A total of 229 persons in Bethel and participating villages have received HIV testing through the project; none have tested positive for HIV. In addition, the project has helped YKHC to introduce rapid testing into their clinical services and there has been an increase in HIV serologic testing at the YKHC hospital.

Crisis Pregnancy Center – *Let’s Talk* Program

Funding Source: HRSA Special Projects of Regional and National Significance – Community Based Abstinence Education (SPRANS – CBAE)

Funding Cycle: September 30, 2005 through September 30, 2008

Funding: \$663,845 annually

Project Contact: Carol Kidwell 907 868-5033

Project website: www.letstalkalaska.com

Project Description:

The goal of Crisis Pregnancy Center’s *Let’s Talk* program is to educate, empower, and encourage youth throughout Alaska to apply the information they receive about the significance of building healthy relationships and the benefits of abstaining from sexual relations until marriage. The program has three objectives: 1) to reach 50 communities per year and teach abstinence and discuss sexually transmitted infections; 2) to assist 20 communities (5 rural, 15 urban) in developing their own abstinence-only education program; and 3) to develop capacity and to serve as a resource.

Kids Are People, Inc. Abstinence Education Program

Funding Source: Section 510 Title V Maternal Child Health Block Grant through Alaska DHSS.

Funding Cycle: July 1, 2005 through June 30, 2007

Funding: \$88,501 annually

Project Contact: Rich McGill 907 376-6016

Project website: www.kidsarepeople.org

Project Description:

This program provides abstinence education for students in seventh and eighth grade, and their parents, through peer outreach and education. The program is also available to high school-aged students who serve as peer educators. The target audience is middle school students before they have become sexually active. The curriculum is Postponing Sexual Involvement (PSI). The program is coordinated by one recipient organization (Kids Are People, Inc.) to implement the PSI curriculum in six school districts in the Kenai Peninsula Borough, Mat-Su Borough, Fairbanks/North Star Borough, Ketchikan, Kodiak, and Juneau. In school year 2005, 57 high school peer educators presented the curriculum to 1,062 middle school students.

Family Planning Services

Source of Funding: US DHSS Title X Family Planning Programs, MCH Block Grants and State funds.

Program Contact: Stephanie Birch, Section of Women’s, Children’s and Family Health 907 334-2400

Program Description:

Family Planning Clinics are provided to high-risk, low-income women and teens at public health centers in Bethel, Craig, Fairbanks, and surrounding communities, Juneau, Kenai Peninsula, Ketchikan and Prince of Wales, Kodiak, and Palmer/Wasilla. Family planning services are also provided on a fee for service basis for private non-profits that are enrolled providers for family planning and adolescent health services in Anchorage, Fairbanks, Homer, and Soldotna. Title X funded programs for Family Planning include HIV education, counseling and testing.

State of Alaska, Department of Education and Early Development

Source of Funding: CDC Division of Adolescent Health (DASH), HIV prevention co-operative agreement.

Funding Cycle: March 1, 2005 through February 2008

Funding: \$225,000 annually

Program Contact: Terri Campbell Terri_Campbell@eed.state.ak.us 907 465-0719

Program Description:

The program funds (\$25,000 to \$35,000 annually) the Youth Risk Behavior Survey and the School Health Education Profile, a survey for Principals and Lead Health Teachers about the health programmatic content in their schools as well as their training and expertise. The remainder of the program funds goes to state trainings and leadership activities for teachers, including Health Education Standards and Assessment trainings and incorporating a focus on health issues through the Healthy Reading initiative. The program also supports trainings for specific high-risk populations, such as youth in juvenile correctional programs.

Comprehensive Behavioral Health Prevention and Early Intervention

Source of Funding: Alaska Division of Behavioral Health

Funding Cycle: July 1, 2005 through June 30, 2006

Funding: Approximately \$3.3 million to 53 grantees

Program Contact: Diane Casto, AK DBH 907 465-3033

Program Description:

The goal of this grant program is to provide integrated behavioral health prevention and early intervention services related to substance use and abuse, suicide, fetal alcohol spectrum disorders, youth development and resiliency, and promotion of wellness in Alaska. The 53 grants awarded for FY2006 range from \$9,000 to \$347,000 with the majority of grants at \$50,000 or less. Grants fund a variety of projects, some single-issue programs such as suicide prevention, and others addressing multiple behavioral health issues. Grantees include school districts, community-based organizations, hospitals and community clinics, Alaska Native health corporations, tribal entities, and rural city governments. The intended populations of the programs variously include youth, adults, elders, individuals and family units.

Comprehensive Behavioral Health Treatment Programs

Source of Funding: Alaska Division of Behavioral Health

Funding Cycle: July 1, 2005 through June 30, 2006

Funding: Approximately \$42.5 million to 62 grantees

Program Contact: Vicki Wells, AK DBH 907 269-3794

Program Description:

Grants are intended to support integrated treatment across the spectrum of behavioral health services including: psychiatric emergency services; services to adults with serious mental illness; services to seriously emotionally disturbed youth; services for individuals with co-occurring mental health and substance use disorders; and individuals with substance abuse disorders. Service populations include pregnant women, IV drug users, women with dependent children, youth, and other persons and families whose presenting problem is addiction to, dependency on, or chronic disabling use/abuse of alcohol and other drugs, including prescribed and over-the-counter medications and household/general use products that contain inhalant chemicals and

substance. Funded programs are statewide and serve all ages. For FY 2006, 46 behavioral health programs, including 23 residential facilities, were funded. Priorities for substance abuse treatment are pregnant women, injection drug users, and women with dependent children. Funded substance abuse treatment programs are required to have staff trained in, and all clients provided, hepatitis, TB, HIV and Fetal Alcohol Spectrum Disorder risk assessment, education, early intervention and risk reduction counseling. The Alaska Commission for the Accreditation of Behavioral Health Professionals requires training in HIV prevention and early intervention. There are only two Methadone maintenance programs funded in the state: the Narcotic Drug Treatment Center in Anchorage and Project Special Delivery in Fairbanks with a combined number of treatment slots of 65.

Alaska Section of Public Health Nursing, Health Centers

Source of Funding: Alaska Division of Public Health

Funding Cycle: ongoing

Program website: www.hss.state.ak.us/dph/nursing/locations.htm

Program Description:

State public health nursing provides services at 20 public health centers, and itinerant services to 250 communities. In addition, the Section of Public Health Nursing provides oversight for public health nursing services in the Municipality of Anchorage, Norton Sound, Northwest Arctic/Maniilaq, and the North Slope Borough. Public Health Centers are located in Anchorage, Bethel, Cordova, Craig, Delta Junction, Dillingham, Fairbanks, Fort Yukon, Galena, Glennallen, Haines, Homer, Juneau, Kenai, Ketchikan, Kodiak, Kotzebue (contract with Maniilaq), Palmer, Barrow (contract with North Slope Borough), Nome (contract with Norton Sound Health Corp.), Petersburg, Seward, Sitka, Tok, Wrangell, and Valdez. Public health nurses provide HIV counseling and testing, STD diagnosis and treatment and HIV/STD partner services. Other services include: immunizations, family planning, pregnancy testing, prenatal monitoring, postpartum home visits, senior clinics, chronic disease services, well child exams, Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT), outreach, screening, and referral, clinics for special needs children, Women, Infants, and Children (WIC) and Infant Learning Program (ILP) referrals, school screenings, audiograms, tuberculosis screening, epidemiological investigations, parenting education, health education, community assessment, and participation in community partnerships in response to public health concerns. There is no cost for any services to children. There is a small cost for adults. However, no one is denied service due to an inability to pay.

University of Alaska, Behavioral Health Research and Services, Exploring HIV Prevention in Brief Alcohol Detox Programs

Funding Source: National Institute on Alcohol Abuse and Alcoholism

Funding Cycle: October 2004 to September 2007

Amount: \$125,000 Year One; \$150,000 Year Two; no cost extension Year Three

Project Contact: Christiane Brems, Ph.D., ABPP; 907-561-2880

Project Description:

This is a research project to explore the use of brief adaptations of motivational interviewing (BMI) in a new venue (brief alcohol detoxification), with high-risk individuals who traditionally have had limited access to HIV prevention interventions. It uses BMI for HIV/STD prevention with this underserved group of individuals who are not yet likely to be motivated to address the issue of HIV/STD prevention. Biological feedback (results of STD testing) is used to enhance

motivational impact. Participants are culturally diverse (45% Alaska Native). During Phase One the project developed session outlines and intervention manuals through focus groups and key informant interviews. During Phase Two, the project is testing the feasibility and utility of the novel application of brief motivational interventions to HIV prevention in culturally diverse clients in brief alcohol detoxification treatment. Three intervention options enroll 25 individuals per condition and have a 3-month follow-up: (a) *Risk Assessment Intervention*: participants respond to a standard risk assessment protocol, receive standard HIV/STD risk reduction information and referral to community services; (b) *Motivational Interviewing Intervention*: participants respond to a risk assessment protocol and receive an HIV/STD prevention intervention based on brief adaptations of motivational interviewing, including personalized risk feedback, personalized risk reduction plans, behavioral skills training, and referral to relevant community services; and (c) *Motivational Interviewing and Biological Feedback Intervention*: participants receive intervention (b) AND pre-test counseling AND provide a biological specimen for STD testing, followed by post-test counseling, STD test feedback, and referral for treatment. All individuals will be assessed after three months.

Table 6. HIV Prevention Funding in Alaska – shaded portion represents the funded period

Program	Period Covered by the 2007 – 2009 Alaska HIV Prevention Plan											
	2006			2007			2008			2009		
	Jan	July	Dec	Jan	July	Dec	Jan	July	Dec	Jan	July	Dec
HIV/STD Program HIV Prevention Cooperative Agreement from CDC												
[FY2007 State HIV Prevention grants/contracts]												
ANTHC SPNS (Norton Sound Region)												
ANTHC Community Promise (Bethel Region)												
YKHC Circle of Care (Bethel Region)												
Let's Talk (Statewide)												
Kids Are People (6 School Districts)												
AK Dept. of Education and Early Development, grant from CDC, DASH												
University of Alaska, Behavioral Research and Services												

HIV Prevention Resources by Intended Population and Geographic Distribution

The majority of resources for HIV prevention are located in urban centers. The majority (60%) of the population resides in the three urban communities of Anchorage, Fairbanks, and Juneau and the majority of HIV/AIDS cases are in persons who resided in one of these cities at the time of diagnosis. HIV infection has historically been, and continues to be, more prevalent in the more populous areas of Alaska, although all geographic areas of the state are affected to some degree. Risk behaviors among people in the urban centers, either by individuals who reside in these areas or who travel to the cities from outlying areas, are therefore more likely to involve exposure to HIV than in areas with lower prevalence of HIV infection. Most of the HIV prevention interventions with evidence of effectiveness are feasible only in settings where there are sufficient numbers of persons in the intended population. The size of the priority population

with demographic and behavioral risk factors in common, for example, injection drug users, men who have sex with men, and women with identifiable risk factors, and their concentration in identifiable locations, make certain interventions like targeted outreach and group sessions feasible in the urban setting. Urban centers may also have concentrations of target populations whose members interact with sufficient frequency to make it possible to influence community norms about HIV risk reduction. The three urban centers also have sufficient populations of persons affected by HIV to have dedicated AIDS service organizations that offer a continuum of HIV care and prevention services and can employ staff who specialize in HIV prevention.

Mid-sized rural hubs and some of the boroughs adjacent to urban centers have health and social service resources that can incorporate HIV prevention into existing services that reach persons at risk such as in substance abuse treatment facilities, public health clinics, and correctional facilities. Alaska Native regional health corporations based in rural hubs provide the health infrastructure to incorporate prevention into the care of beneficiaries living with HIV, provide HIV counseling and testing, reproductive health care including STD diagnosis and treatment, and in some instances, conduct projects dedicated to HIV prevention. However, in less populous areas of the state, the smaller numbers of people, particularly those in the priority populations based on behavioral risk factors, as well as lower HIV prevalence, often preclude establishment of AIDS specific organizations or prevention programs focused exclusively or predominantly on HIV and staffed by HIV prevention specialists. In these areas, the intensive interventions of partner notification and prevention case management for HIV-positive persons can be provided for the small number of persons for whom they are appropriate. However, other HIV prevention activities generally must rely heavily on agencies and organizations with broader missions that can integrate HIV prevention into counseling or health education services for their clients and communities. Lower population density, lower HIV prevalence, social dynamics and cultural factors of rural communities make it difficult to provide HIV prevention activities that target persons with acknowledged, specified behavioral risk factor such as injection drug use or sex between men. In rural areas, most HIV prevention efforts must reach out to a broader audience of persons potentially at risk to raise awareness of risk and provide referrals to individualized services for the fewer individuals at higher risk.

Table 7 summarizes the geographic distribution of HIV resources for each of the priority populations identified in the previous Alaska HIV Prevention Plan (2004-2006).

Table 7. HIV Prevention Resources by Priority Population, Geographic Distribution and Agency Funded through June 2007

Population (% of state)	Anchorage (42%)	Fairbanks (13%)	Juneau (5%)	15 Urban Satellites and Rural Hubs (25%)	260 Towns/Villages with ≤2,000 residents (15%)
HIV-Positive Persons	Partner Services	PS	PS	PS	PS
	Four A's RW II AIDS Drug Assist. Program (ADAP)	IAA RW II ADAP	Four A's RWII ; ADAP		
	Four A's <i>Healthy Relationships</i> <i>CD4 Group GrpSS</i>				
	ANHC: PCM and Individual HE/RR				
	ANHC RW III				
	ANTHC RW III	ANTHC RW III	ANTHC RW III	ANTHC RWIII, Sitka & Bethel	
MSM	Partner Services	PS	PS	PS	PS
	MSM<29y/o Four A's MPowerment			ANTHC: AK Native and Rural MSM POL (Bethel and Dillingham)	
	MOARHC: HIVCT			May reach men in villages	
	ANTHC: AK Natives in Anch. MPowerment				
IDU	Partner Services	PS	PS	PS	PS
	Four A's: DOC groups; ANHC: DOC groups for women.	IAA: OR; Safety Counts			
	STOP AIDS –HIV CT	Needle exchange			
	State-funded Substance Abuse Treatment Programs				
Heterosexual Women especially Alaska Native and other ethnic minority women	Partner Services	PS	PS	PS	PS
	Four A's RAPP OR and Group SS ANHC Group SS (DOC) Group MS (substance abuse treatment programs) MOA HIVCT	IAA OR Group MS	Four A's Group SS		
	State-funded Substance Abuse Treatment Programs				
	HIVCT through prenatal care at tribal health facilities, private providers, and military health facilities.				

Table 7. HIV Prevention Resources by Priority Population, Geographic Distribution and Agency Funded through June 2007

Population (% of state)	Anchorage (42%)	Fairbanks (13%)	Juneau (5%)	15 Urban Satellites and Rural Hubs (25%)	260 Towns/Villages with ≤2,000 residents (15%)
Incarcerated	Partner Services	PS	PS	PS	PS
	Four A's, (DOC): Group SS				
	ANHC Women (DOC) Group SS				
	Voluntary HIVCT and STD treatment – All DOC facilities				
Youth at Increased Risk	Partner Services	PS	PS	PS	PS
	AYPF: OR; Group SS, Group MS	IAA: Group MS			
	ASD: Group SS				
	AK Division of Juvenile Justice facilities: Group MS (Making Proud Choices Curric.); HIVCT and STD services. Let's Talk, Crisis Pregnancy Center, Abstinence education programs. Kid's Are People, Abstinence education programs.				
	State-funded Substance Abuse Treatment Programs - HIV education is required in treatment plan for all clients.				
Alaska Native General Population				ANTHC Community Promise, Bethel and YK villages	
				YKHC Circle of Care HC/PI and HIVCT, Bethel and YK villages	
	AK Native Health Corp health education and behavioral health programs				
	State-funded Substance Abuse Treatment Programs HIV education is required in treatment plan for all clients.				
	HIVCT, STD, and PN - State-funded and PL93-638 contracted Public Health Nursing				
HIVCT and STD treatment – AK Native tribal health facilities, itinerating providers, and some village health aides.					

*Key to Prevention Interventions: **OR** – Outreach; **IND** – Individual Health Ed./Risk Reduction (HE/RR) Counseling; **Group SS** – Single session Group HE/RR; **Group MS** - Multiple Session Group HE/RR; **PCM** – Prevention Case Management; **HIVCT** – HIV Counseling and Testing; **PS** – Partner Services and Disease Intervention; **HC/PI** – Health Communication/Public Information.

Key to Agencies: **Four A's** – Alaskan AIDS Assistance Assoc.; **IAA** – Interior AIDS Association; **ANHC** – Anchorage Neighborhood Health Center; **AYPF** – Alaska Youth and Parent Foundation; **ANTHC** – Alaska Native Tribal Health Consortium; **RW** – Ryan White Care Grant; **HRSA SPNS** – Health Resource Service Admin, Special Projects of Nat'l Significance; **ASD** – Anchorage School District; **MOARHC** – Municipality of Anchorage Reproductive Health Clinic.

Population-specific Indications of Need, Resources and Gaps

In the following section, needs, resources and gaps are described for each of the potential priority populations as indicated by the data on HIV/AIDS cases in Alaska and other risk factors. Prevention services are organized by funding source. The services described are those in effect in 2006.

HIV-Positive Persons

Indication of Need

The Ryan White CARE grant 2006 Statewide Coordinated Statement of Need (SCSN) identifies three overarching issues for persons living with HIV in Alaska:

1. The changing nature of HIV disease. New therapies and medical technologies have prolonged health and life for many persons living with HIV (PLWHIV), making HIV a long term, chronic illness. These changes have also made HIV a very complex illness for providers and patients to manage.
2. The changing populations affected by HIV. Individuals with HIV are increasingly drawn from socially and economically marginalized populations, and many PLWHIV have complex co-existing medical and social needs.
3. Many potential barriers exist to effective participation in HIV care. Comprehensive care is unevenly available in different geographic areas of the state and within different care systems. Some services are not fully integrated and various services have different eligibility requirements. Barriers posed by high costs of care, geographic distances, differences in culture, differences in language, competing family or other demands, and real or perceived stigma impede some individuals from accessing services.

To the extent that a lower HIV viral load reduces the risk of HIV transmission, adherence to HIV medications contributes to HIV prevention. The 2006 SCSN notes that adherence to prescribed medication regimens is difficult for many, if not all PLWHIV, due to the nature of the medications (timing, with/without food, drug interactions, sheer quantities of pills, etc.) and these medications' many toxicities. Individuals with substance abuse or mental health problems may have additional difficulties with adherence or providers may be reluctant to prescribe certain HIV medications for them at all. Programs to support adherence are limited. Currently, the private pharmacy that provides AIDS Drug Assistance Program (ADAP) services and the ANHC and ANTHC Title III projects all assist patients with adherence. Additional efforts to support adherence (including opportunities for monitored or directly observed therapy as medication regimens are simplified) are needed.

Mental health problems affect adherence and a person's ability to adopt and maintain safer behaviors. According to the 2006 SDSN, PLWHIV with co-existing mental health problems face special challenges. Title II and Title III providers estimate that anywhere from 35% to 80% of the PLWHIV in care are in need of some level of mental health services. Not all individuals

will seek services. The stigma surrounding mental health problems may be perceived as more damaging than those related to HIV. This may be especially true for some rural residents who need to access itinerant providers for mental health services. To make mental health counseling more accessible and normalize mental health services the lead agency for one Title II consortium offers counseling at its office. Persons with more severe mental health problems have more subsidized service options available to them, but continuity of care may be an issue. Persons with mental illness and disruptive behaviors have limited service options.

PLWHIV with substance abuse problems face special challenges to follow medical care schedules and medication regimens. Substance abuse also increases the risk of engaging in transmission risk behaviors. According to Title II and III providers, alcohol is the most prevalent drug of abuse for Alaska PLWHIV and case managers have identified that from 80 to almost 100% of clients have substance use issues. Treatment services are available in most areas of the state, although the different levels and types of treatment are not uniformly available in all areas. Some individual factors may not be well accommodated (for example, lengths of stay may be prescribed rather than individually established, services may not be perceived as culturally sensitive, child care may be unavailable to those who need it), and some treatment services (both inpatient and outpatient) have wait lists. Access to treatment is problematic for substance abusing individuals with HIV dementia and/or who have disruptive behaviors.

Other needed support services may be negatively affected by a person's substance abuse problem and may indirectly complicate medical care and prevention (for example, public housing has a zero tolerance for substance abuse and abusers may be evicted). Many clients need supportive aftercare and ongoing counseling after substance abuse treatment to assist them in controlling their substance abuse, and special services may be needed to support adherence to HIV (and other) medical regimens. When individuals face delays for admission to substance abuse treatment, case managers must assist clients to stay in care while waiting, which may be very challenging.

HIV positive persons who are not accessing medical care are not likely to be accessing prevention services. Factors that contribute to avoidance of care, identified by Title II and III providers, include:

- Perceived stigma associated with disclosing HIV status,
- Residence in areas where services are not readily available necessitating travel that is complicated by cost and competing needs, and
- substance abuse issues or disruptive behaviors.

PLWHIV released from incarceration in correctional settings in Anchorage receive logistic and financial assistance to access medical care and medications, as well as other supportive services upon release. This pre-release case management is not routinely available across the correctional system in other areas of the state.

CDC estimates that 25% of persons infected with HIV have not been tested and are thus unaware of their HIV status. Diagnosis as early as possible is critical for initiating care to prevent disease progression and to decrease disease transmission. In Alaska, HIV partner services have proven to be the most effective mechanism for identifying previously undiagnosed cases of HIV.

Partner notification and the offer of immediate, field-based HIV counseling and testing can facilitate earlier diagnosis of HIV infection and provide prevention counseling to those at risk of transmitting HIV. Of all newly reported cases of HIV/AIDS in 2003, 2004 and 2005, 37%, 44% and 24% respectively were first identified through partner services.

HIV and STD co-morbidity may increase the risk of HIV transmission. Low cost, accessible services for STD diagnosis and treatment make an important contribution to HIV prevention by (a) reducing STD morbidity which is a risk factor for HIV transmission and (b) reaching persons for whom HIV counseling and testing may be appropriate who might not otherwise seek out HIV testing and risk reduction counseling.

Prevention Services

State-funded Interventions under the CDC Cooperative Agreement

Partner services, including field-based HIV counseling and testing, carried out by the HIV/STD Program are funded under the CDC Cooperative Agreement through 2008. In Anchorage, the Alaskan AIDS Assistance Association has implemented the *Healthy Relationships* multi-session group prevention intervention and an adaptation of the MPowerment model with outreach and single group sessions for persons living with HIV. The Anchorage Neighborhood Health Center receives prevention funding to provide prevention case management and individual health education/risk reduction (HE/RR) in the context of medical care at ANHC. The Municipality of Anchorage Reproductive Health Clinic is funded under the CDC Cooperative Agreement to conduct HIV counseling and testing in community settings and to conduct STD partner services and testing. HIV prevention funds also partially support public health nursing positions (historically in Fairbanks, Juneau and Bethel) to provide HIV counseling and testing and HIV/STD partner services.

HIV-specific Services Directly Funded by Federal Agencies

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act authorizes federal funding to (1) increase the availability of primary health care and support services, (2) reduce utilization of more costly inpatient care, (3) increase access to care for underserved populations, and (4) improve the quality of life for persons living with HIV disease. Several entities in Alaska receive funding under different parts of the CARE Act. Title II CARE Act funds the State of Alaska to purchase medical services, medications, and supportive services such as case management that assist low income PLWHIV/AIDS to participate in medical care. The Four A's, with offices in Juneau and Anchorage, receives Title II CARE funds to serve clients statewide except for Fairbanks and surrounding Interior communities that are served by the Interior AIDS Association in Fairbanks. CARE services include a prevention counseling component and other support services that help HIV-positive persons reduce their risk of transmission.

There are two recipients of Ryan White Title III Early Intervention Services (EIS) funding in Alaska, the Anchorage Neighborhood Health Center (ANHC) and the Alaska Native Tribal Health Consortium (ANTHC). ANHC provides comprehensive primary health care for individuals living with HIV disease. Title III services include: risk-reduction counseling, antibody testing, medical evaluation, and clinical care; antiretroviral therapies; protection against opportunistic infections; and ongoing medical, oral health, nutritional, psychosocial, and other care services for HIV-infected clients; case management to ensure access to services and

continuity of care for HIV-infected clients; and attention to other health problems that occur frequently with HIV infection, including tuberculosis and substance abuse.

ANTHC receives Ryan White Title III funding for Early Intervention Services to develop and provide HIV/AIDS case management, and treatment for Alaskan Natives and rural Alaskans. A centralized clinical team is located in Anchorage, and hub site coordinators in Anchorage, Bethel, Fairbanks, Juneau, and Sitka provide regional case management. The EIS team provides program services, such as consultation, collaborative patient case management, and HIV clinics. Case management for HIV-positive patients includes prevention counseling in addition to coordination and referrals for medical and counseling services.

State-funded Services

The State Virology Laboratory provides HIV antibody and confirmatory tests at no cost to public or private providers. HIV counseling and testing, and STD diagnosis and treatment are provided at most state-funded Public Health Nursing Centers and by public health nurses at tribal health clinics under PL93-638 contracts with the state. Public health nurses also work closely with HIV/STD Program staff to carry out partner notification activities in rural communities.

Service Gaps

Supportive services are needed to assist persons with HIV over the long run to adopt and maintain healthy behaviors that prevent transmission of HIV and prevent progression to AIDS. Behavioral intervention models, such as *Healthy Relationships*, specifically designed for HIV-positive persons are currently only available in Anchorage. The challenge is to provide a variety of prevention services in order to sustain interest and availability over time. Funding for these programs under the State's CDC cooperative agreement expires in mid-2007 after which this will be a gap in prevention services.

Outside of Anchorage, group interventions are not feasible due to low HIV/AIDS prevalence and consumer concerns about disclosure. Client-centered individual prevention counseling is needed. Individual risk reduction counseling for HIV positive persons in the context of Ryan White CARE services is available in Fairbanks and Juneau, and in two rural hubs (Sitka and Bethel) served by the Alaska Native Tribal Health Consortium Early Intervention Services.

HIV and STD partner services must continue uninterrupted statewide. Current funding for HIV and STD partner services conducted by the HIV/STD Program expires in December 2008. Funding for HIV/STD partner services conducted by grantees expires mid-2007.

Assessment of the prevention needs and preferences of HIV positive persons is needed on an ongoing basis to guide future prevention efforts.

Men Who Have Sex With Men

Indication of Need

Yearly incident HIV cases among men who have sex with men (MSM) and the outbreak of syphilis in Alaska between 2004 and 2006 indicate that unprotected sex continues to be a risk factor (MSM). Men with newly diagnosed HIV infection who name as partners men who have been previously diagnosed with HIV indicate either that disclosure of HIV status is not a community norm and/or there is complacency about transmission risk.

Partner notification activities conducted by the HIV/STD Program indicate that a number of HIV-positive men and the men they name as sex partners do not identify as gay. Such individuals may not regard as relevant messages or interventions aimed at gay men.

Prevention Services

State-funded Interventions under the CDC Cooperative Agreement

The Four A's in Anchorage provides HIV prevention to young adult MSM in Anchorage through an intervention based on the MPowerment model developed by the Center for AIDS Prevention Studies (listed in the *CDC Compendium of Interventions with Evidence of Effectiveness*).

MPowerment is a peer-led program that seeks to address the needs of young gay and bisexual men by providing HIV prevention within the context of social activities, formal and informal outreach, a safe community center or gathering spot, and small group sessions. Peer volunteers conduct outreach in bars, adult bookstores, public sex environments, and through Internet chat rooms, reaching MSM including those who do not identify as gay. In 2005, the MPowerment project made 8,200 outreach contacts with men; 96 young men participated in groups.

The Municipality of Anchorage conducts targeted HIV counseling and testing in non-clinic settings readily accessible to men in conjunction with the MPowerment Project outreach activities. In 2005, 151 MSM received HIV counseling and testing in community settings.

The Alaska Native Tribal Health Consortium provides an adaptation of the MPowerment model for HIV prevention for Alaska Native MSM in Anchorage and an adaptation of the POL outreach model for rural MSM in selected regional hub communities. In 2005, there were 1,450 outreach contacts from the two projects and 75 men participated in group sessions.

HIV Partner Services conducted by public health personnel from the HIV/STD program provides prevention counseling and care referrals to MSM whose HIV/AIDS diagnosis is newly reported and then provides notification and HIV counseling and testing for named partners. This service is available statewide.

Service Gaps

MSM-specific behavioral interventions and MSM-targeted HIV testing in community settings are only available in Anchorage, with the addition of POL outreach in the rural hub communities of Bethel and Dillingham. With the exception of limited private funding to one of the Anchorage CBOs, all funding for these interventions is from the State under the CDC cooperative agreement and expires mid-2007, after which prevention for MSM in Anchorage and

the two rural hubs will be an unmet need. Prevention interventions for MSM are needed in other communities besides Anchorage.

Injection Drug Users

Indication of Need

Users of illicit drugs need prevention interventions that address the risk of sexual transmission of HIV. Disease investigation of an outbreak of syphilis between mid-2004 and mid-2006, indicated an emerging overlap in the sexual networks of MSM and drug users related to production and use of methamphetamine. Drug users who do not identify as MSM may have a low perception of risk of sexual transmission and are not likely to avail themselves of interventions designed for gay men. Similarly, women sexual partners of drug users (whether or not the women inject drugs) have indicated a low perception of risk of sexual transmission. In interviews and focus groups with female drug users conducted in Anchorage between 2001 and 2002 women reported infrequent use of condoms with casual partners or when exchanging sex for money or goods. Women were even less likely to use condoms with their main male partners, even knowing of their male partner's drug use. Women also indicated a relationship between their partner's substance abuse and coercive sex. The research concluded that there is a need to increase the availability of HIV testing, condoms and educational material, and awareness-raising interventions for women drug users and women with drug-using partners.

Input from active injection drug users in focus groups in Anchorage in 2002 indicated knowledge of the HIV and viral hepatitis transmission risk from sharing injection equipment. Most participants agreed that paraphernalia sale laws were not a major obstacle to purchasing needles and syringes. However, stigma and individual pharmacy policies and practices discourage purchase at pharmacies, leading participants to express interest in a syringe exchange program. In 2006, Alaska enacted new restrictions on the sale of pseudo-ephedrine and other precursors used in the manufacture of methamphetamine. It remains to be seen if the increased scrutiny of customers at pharmacies will be an additional deterrent to the purchase of clean syringes by illicit drug users.

Prevention Services

State-funded Interventions under CDC Cooperative Agreement

Interior AIDS Association in Fairbanks is funded to provide targeted street outreach and other behavioral interventions for IDU.

State-funded Services

The Division of Behavioral Health (DBH) which includes the former Division of Alcoholism and Drug Abuse (ADA) requires that all individuals entering substance abuse treatment have access to infectious disease screening, risk reduction education, counseling, and medical services, including diagnosis and treatment for HIV. Since 1997, notices of grant awards for funding for substance abuse treatment programs have contained the following HIV-related requirements: (a) referrals for counseling, testing, and treatment; (b) staff member trained in risk reduction; and (c) HIV issues addressed in client education and treatment plans. Furthermore, there are requirements that are specific to IDUs. IDUs have priority access to treatment, must be

admitted no later than 120 days after requesting treatment, and must receive interim services (e.g., counseling and education about HIV and TB, referrals for HIV and TB testing, referrals for prenatal care for IDUs who are pregnant) while awaiting treatment.

DBH funds two methadone treatment programs, one in Anchorage and one in Fairbanks (co-located with Interior AIDS Association). The STOP AIDS Project within the Center for Drug Problems (CDP) in Anchorage offers individual risk reduction counseling to all CDP clients and provides anonymous HIV counseling and testing to clients and the public.

Non-public Funding

Northern Exchange, funded by private foundations and donations, provides clean syringes, condoms, and referral information about HIV prevention and drug treatment resources in Fairbanks to active IDU. The program relies heavily on secondary exchange whereby primary exchangers pick up new syringes and return used syringes for other IDU in their social networks. Because of stigma and confidentiality concerns, and dispersed rather than concentrated networks, this approach has proven more acceptable to users than requiring them to interact individually with the program. In Fairbanks, Northern Exchange distributes approximately 20,000 clean syringes each year and collects about 95% of these for safe and appropriate disposal.

Service Gaps

IDU-specific interventions are most feasible in the larger cities –Anchorage, Fairbanks, and Juneau. Due to stigma and confidentiality concerns, recruitment and retention of active drug users for interventions that involve group sessions is problematic. Individual level interventions that rely on social networks may have greater success in engaging active drug users both in urban settings and in areas where users are more widely dispersed.

Harm reduction programs providing sterile syringes and opioid substitution therapies are needed. There are methadone maintenance programs only in Anchorage and Fairbanks. There is no IDU outreach in Anchorage, or in less populous areas of the state. A privately funded syringe exchange program is operating successfully in Fairbanks, but is needed elsewhere. There is no syringe exchange program in Anchorage.

State funding under the CDC cooperative agreement currently supporting interventions for IDU in Fairbanks expires mid-2007, after which this will be a gap in services in Fairbanks.

Heterosexual Women at Increased Risk

Indication of Need

Among cases of HIV diagnosed in women in the past five years in Alaska, 54% were among women whose risk factor was sexual contact with a man with HIV, a bi-sexual male or male IDU. The high incidence of STDs in women in Alaska (see Appendix A: Epidemiologic Profile) is another indicator of sexual risk behavior among heterosexual women. Epidemiologic data for Alaska indicate that minority women, especially Alaska Native women, are disproportionately affected by STD and HIV. Low cost, accessible services for STD diagnosis and treatment make an important contribution to HIV prevention by (a) reducing STD morbidity which is a risk

factor for HIV transmission and (b) reaching women for whom HIV counseling and testing may be appropriate but who might not otherwise seek out HIV testing and risk reduction counseling. Similarly, STD partner notification is an important service for persons exposed to an STD, especially for those with asymptomatic STD infection who are not aware of their infection. STD partner notification also facilitates prevention counseling and HIV testing for those for whom it is appropriate. Many women whose sole risk is heterosexual contact and who test HIV-positive or who are named as a partner of an HIV-positive man, are unaware of their risk. AIDS service organizations have reported that women clients say they were unaware of their partners' risk behavior or HIV status prior to the women's own HIV diagnosis. Women are unlikely to avail themselves of HIV prevention activities specifically recruiting women at risk. Rather, HIV prevention efforts must be incorporated into services reaching women at increased risk such as STD clinics, substance abuse treatment programs, correctional facilities and community residential centers (pre-release programs), and programs for homeless and victimized women. Needed also are HIV counseling and testing, especially in non-clinic settings outreaching to homeless and substance abusing women and sex workers, and provision of or referrals for HIV testing for women receiving treatment for STDs. Because women often do not perceive themselves or their sexual partners to be at risk for HIV, partner notification services are important for early detection of HIV and for providing risk reduction counseling for HIV-negative women at high risk.

Routine, voluntary HIV testing of pregnant women during prenatal care, in addition to facilitating prevention of perinatal transmission, is a mechanism for reaching women who do not perceive themselves at risk or who have deferred testing for other reasons. Routine prenatal HIV testing appears to be well accepted by providers and pregnant women in Alaska. Data from the Alaska Pregnancy Risk Assessment Monitoring System showed that 80% of women delivering a live-born infant in 2003 reported that a health care worker discussed blood testing for HIV during their prenatal care. A review of records of Alaska Native women receiving prenatal care in 2005 through Southcentral Foundation, an Alaska Native health clinic in Anchorage, showed that 97% accepted HIV testing.

Prevention Services

State-funded Interventions under the CDC Cooperative Agreement

The Four A's is funded to provide an intervention for minority women in Anchorage and Juneau based on the Real AIDS Prevention Project (RAPP), a multi-strategy community-based intervention model that includes targeted social marketing, peer outreach, small group sessions and community mobilization. The Anchorage Neighborhood Health Center (ANHC) is funded to conduct multi-session health education/risk reduction groups for women in substance abuse treatment programs and single session groups in Highland Mountain correctional center for women. Interior AIDS Association in Fairbanks conducts street outreach to women and multi-session health education/ risk reduction groups for women in substance abuse treatment programs and shelters. The Municipality of Anchorage Reproductive Health Clinic is funded to conduct HIV counseling and testing in community venues and women-serving programs in conjunction with ANHC prevention activities. The Municipality is also funded to do STD and HIV partner services in Anchorage. The HIV/STD Program provides HIV partner services for all persons newly reported with HIV/AIDS and their sex and needle sharing partners. The

HIV/STD Program provides STD partner services for persons with a newly diagnosed STD in the Anchorage bowl including persons incarcerated in correctional facilities.

HIV-specific Services Directly Funded by Federal Agencies

The Alaska Native Tribal Health Consortium (ANTHC) is funded through 2008 by CDC to conduct HIV prevention activities in Bethel and some villages in the Yukon-Kuskokwim Delta. ANTHC is also funded by the federal Health Resources and Services Administration (HRSA) for a Special Projects of National Significance (SPNS) for HIV prevention and linkage to care services in the Norton Sound region. These projects in rural Alaska are a resource for women although they are not gender specific.

State-funded Services

Women in substance abuse treatment programs statewide receive HIV information and access to HIV and STD testing. The Division of Behavioral Health (DBH) which includes the former Division of Alcoholism and Drug Abuse (ADA) requires that all individuals entering substance abuse treatment have access to infectious disease screening, risk reduction education, counseling, and medical services, including diagnosis and treatment for HIV.

Public Health Clinics statewide provide women's reproductive health care including STD testing and partner follow-up and HIV counseling and testing on request.

Service Gaps

Health education/risk reduction group sessions for women at increased risk are available only in three urban centers through grantees receiving State funds under the CDC cooperative agreement through mid-2007. HIV counseling and testing for women in community settings is provided by the Municipal of Anchorage Reproductive Health Clinic. These activities are currently funded only through mid-2007.

STD partner services are not available in all areas of the state.

HIV-specific interventions and social marketing efforts are needed in rural Alaska. Currently funded activities are limited to a few communities in the Yukon-Kuskokwim Delta and Norton Sound region through federally funded special projects.

Culture- and gender-specific programming and materials are needed for ethnic minority women in both urban and rural communities.

Additional data on the prevention needs and preferences of women at increased risk are needed to guide future HIV prevention efforts.

Heterosexual Men at Increased Risk

Indication of Need

Among cases of HIV diagnosed in men in the past five years in Alaska, 15% were among men for whom the only disclosed risk factor was sexual contact with an HIV-positive woman, or who

came from a country with a high prevalence of heterosexually transmitted HIV. Men in minority ethnic populations, especially Alaska Natives and Blacks, are overrepresented in HIV and STD case rates in Alaska. Since some STDs are often asymptomatic in men, STD partner notification is an important service for men exposed to an STD who are not aware of their infection. STD partner notification also facilitates prevention counseling and HIV testing for those for whom it is appropriate. Results of the investigation of a syphilis outbreak in Alaska between 2004 and 2006 indicate an overlap in the sexual and drug using networks of MSM and non-gay identified men who are involved in methamphetamine production and use. Men who do not identify as MSM or IDU appear to have a low perception of HIV risk and are unlikely to seek out prevention interventions including HIV counseling and testing. Rather, HIV prevention efforts must be incorporated into services reaching men at increased risk such as STD clinics, substance abuse treatment programs, correctional facilities and community residential centers (pre-release programs), and services for homeless men.

State-funded Interventions under the CDC Cooperative Agreement

Because heterosexual men were not identified as a priority population in the *2004-2006 Alaska HIV Prevention Plan*, there are currently no interventions funded under the CDC Cooperative Agreement specifically targeting this segment of the population. However, funded interventions targeting other priority populations do reach heterosexual men at increased risk. Outreach conducted by the MPowerment program in bars, adult book stores, and on-line chat rooms reach men who identify as heterosexual. Municipality of Anchorage HIV counseling and testing of incarcerated persons in community release centers and testing in community venues to reach MSM also reach men who identify as heterosexual. HIV and STD partner services conducted by the HIV/STD Program and by the Municipality of Anchorage are a very important mechanism for bringing HIV and STD testing and risk reduction counseling to men at high risk but who have low perception of risk.

HIV-specific Services Directly Funded by Federal Agencies

The Alaska Native Tribal Health Consortium (ANTHC) is funded through 2008 by CDC to conduct HIV prevention activities in Bethel and some villages in the Yukon-Kuskokwim Delta. ANTHC is also funded by the federal Health Resources and Services Administration (HRSA) for a Special Projects of National Significance (SPNS) for HIV prevention and linkage to care services in the Norton Sound region. These projects in rural Alaska are a resource for men although they are not gender specific.

State-funded Services

Men in substance abuse treatment programs statewide receive HIV information and access to HIV and STD testing. The Division of Behavioral Health (DBH) that funds substance abuse treatment programs statewide requires that all individuals entering substance abuse treatment have access to infectious disease screening, risk reduction education, counseling, and medical services, including diagnosis and treatment for HIV.

Gaps

There are currently no HIV prevention activities specifically targeting men who identify as heterosexual. There is a need to increase awareness of HIV risk related to high risk sexual behavior associated with the production and use of methamphetamine in Alaska. There is a need

to increase HIV education and access to HIV testing in services reaching men who may be at increased risk due to drug use and sexual activity but who, because of their sexual identity, have a low perception of risk. STD partner services help identify persons with risk behaviors for whom HIV testing is appropriate, but STD partner services are not available in all areas of the state.

Incarcerated Persons

Indication of Need

According to the Alaska Department of Corrections (DOC), the average daily population of incarcerated persons in Alaska in January 2006 was 4,617 males and 529 females. Alaska Natives, constituting 35% of persons in correctional centers and community release facilities, were over-represented in the incarcerated population compared to their representation in the state's population. Blacks were slightly overrepresented, making up 10.5% of the DOC census.

Persons in correctional institutions are assumed to be at increased risk for HIV because of the large proportion that is incarcerated for drug related offenses. Additionally, situational male-to-male sex and sharing injection, piercing or tattooing equipment may occur in prison. Nationally, the Department of Justice reports that, as of the end of 2003, 2.0% of state prison inmates and 1.1% of federal prison inmates were known to be infected with HIV. In Alaska, as of the end of 2002, the number of inmates with HIV was 16; 0.5% of the total custody population. This HIV prevalence is lower than that of the national rate for incarcerated, but higher than the estimated HIV prevalence for the state as a whole.

The Arrestee Drug Abuse Monitoring Program (ADAM) study, funded by the National Institute of Justice, conducts voluntary, anonymous drug testing and interviews with arrestees (National Institute of Justice, 2006). Data reported on study participants from DOC facilities in Anchorage in 2003 indicated that 66% of male and 52% of female arrestees tested positive for drugs. Among male arrestees, 25% tested positive for cocaine; 0.7% for methamphetamine; and 7.4% for heroin. Among female arrestees, 36% tested positive for cocaine; 2.1% for methamphetamine; and 5.3% for heroin.

Prevention Services

State-funded Interventions under CDC Cooperative Agreement.

The HIV/STD Program provides HIV and STD partner services for inmates in correctional facilities in Anchorage, and coordinates HIV/STD partner elicitation and notification with Department of Corrections medical staff in other DOC facilities statewide. The Four A's is funded to conduct group Health Education/Risk Reduction (HE/RR) sessions in DOC community release centers in Anchorage and Juneau. The Anchorage Neighborhood Health Center also conducts single-session HE/RR groups for incarcerated women at the Highland Mountain Correctional Center in Eagle River. In 2005, 594 incarcerated men and 163 women attended these groups. The Municipality of Anchorage Reproductive Health Clinic is funded to conduct HIV counseling and testing in community release centers in Anchorage in conjunction with the Four A's HE/RR sessions. Community based organizations have identified structural impediments to conducting group HE/RR sessions in correctional centers and community release centers including cancellations due to security procedures, room limitations, disinterested

participants due to mandatory attendance policies in some settings, low attendance in other settings, high drop-out rates from multi-session interventions due to release or transfer, presence of correctional officers, and restrictions on distributing condoms for skill building exercises.

State-funded Services

The DOC Inmate Substance Abuse Program (ISAP) has been eliminated except in two DOC facilities that have therapeutic communities – for sex offenders in the Wildwood Correctional Center in Kenai and in the Highland Mountain women’s facility. Formerly, ISAP programs incorporated HIV prevention education in their programming. The demise of this programming has increased the gap in HIV prevention services for inmates. Some Reformation and Habilitation Programs in DOC facilities may include health topics including HIV prevention. See http://www.correct.state.ak.us/corrections/institutions/programs_list.htm for DOC programs.

All Division of Juvenile Justice (DJJ) facilities have youth correctional staff trained in the *Making Proud Choices (Be Proud/Be Responsible!)* curriculum. There are DJJ youth facilities in Anchorage, Bethel, Fairbanks, Juneau, Kenai, Ketchikan, Palmer and Nome. Group HE/RR sessions following this model are conducted on a regular basis at the larger DJJ facilities and, when feasible, at smaller DJJ facilities. The Alaska Department of Education and Early Development funds training in this curriculum for DJJ staff and

Voluntary HIV and STD testing is available upon request at all DOC and DJJ facilities.

Service Gaps

Interventions in adult correctional programs conducted by CBOs in Anchorage are funded only through mid-2007.

With the elimination of DOC ISAP programming in July 2003, only Highland Mountain and Wildwood correctional centers have substance abuse treatment programs that can incorporate HIV prevention education.

There is no systematic HIV or STD screening for adults remanded to correctional facilities. Except in the context of HIV and STD partner notification activities, HIV and STD testing is dependent on an inmate initiating a request to see a health care provider.

Youth at Increased Risk

Indication of Need

Data on teen pregnancy rates and STD morbidity (see Epidemiologic Profile) indicate the prevalence of sexual risk activity among adolescents. Alaska teens aged 15-19 years consistently have disproportionately high rates of chlamydia and gonorrhea. Data from the Alaska Youth Risk Behavior Survey (YRBS) indicate reduction in some risk behaviors over time, while also indicating the continuing presence of risk. YRBS data show a decrease from 1995 to 2003 in the number of high school students who report ever having sexual intercourse. There was a decrease from 48% to 40% in boys and from 46% to 40% in girls. In 2003, the percentage of high school students who report ever having had intercourse was lower for both boys and girls in Alaska than

the national percentages for boys (48.5%) and girls (43%). The percentage of Alaska students reporting ever having had sexual intercourse varies by grade level from 22.4% in ninth grade to 60% of twelfth graders. Condom use among sexually active students has increased since 1995. In 2003, 62% of sexually active high school students reported having used a condom during the last instance of sexual intercourse. This is an increase of 7% for boys and 11% for girls. Use of alcohol or drugs before last sexual intercourse was reported by 25% of sexually active teens. This represents a slight decrease for boys since the 1995 survey. Among all students in 2003, 75% reported ever using alcohol, a decrease from 80% in 1995; 39% reported current use of alcohol, a decrease from 48% in 1995; and 27% reported binge drinking in the 30 days prior to the survey, a decrease from 31% in 1995.

Prevention Services

State-funded Interventions under CDC Cooperative Agreement

The Alaska Youth and Parent Foundation in Anchorage is funded to conduct an outreach program titled, Peer Outreach Worker Education and Referral (POWER) Program. The POWER Program hires and trains teenagers to provide community referrals, HIV/STD education, information, and mentoring to youth in Anchorage. In 2005, the program logged over 9,000 outreach contacts with youth on streets, in malls, recreation centers, and other sites catering to youth at increased risk. Approximately one quarter of these contact were with Alaska Native youth.

The Anchorage School District is funded to provide group single sessions using the "RARE-T" (Reduce AIDS Risk Effectively in Teens) curriculum. This intervention uses peer educators targeting the general secondary school population and youth at increased risk in alternative schools. The curriculum was initially developed for adolescents by the National Institute on Drug Abuse. In 2005, there were 5,098 participants in RARE-T presentations.

Group HE/RR sessions using the *Making Proud Choices (Be Proud/Be Responsible!)* curriculum are offered by CBOs at agencies serving youth at increased risk in Anchorage and Fairbanks.

State-funded Services

The Alaska Department of Education and Early Development receives, CDC, Division of Adolescent and School Health (DASH) funds for school-based health education to prevent the most serious health risk behaviors among children, adolescents and young adults. In Alaska, these funds are used to conduct the Youth Risk Behavior Survey and the School Health Education Profile, to purchase HIV prevention curricula materials and support teacher training in the delivery of these curricula, and training for teachers on health education standards and assessment. The Alaska Department of Health and Social Services receives additional federal funds to promote an abstinence-only program, "Postponing Sexual Involvement" targeting middle school students. Alaska Division of Juvenile Justice facilities offer multiple session group HE/RR using the *Making Proud Choices (Be Proud/Be Responsible!)* curriculum and provide STD testing and treatment. State-funded substance abuse treatment programs for youth are required to provide HIV education and risk reduction counseling.

Prevention Education Directly Funded by Federal Agencies

Currently there are two federally funded abstinence education programs for youth in Alaska - the *Let's Talk* Program conducted by the Crisis Pregnancy Center and the *Postponing Sexual Involvement* curriculum for middle school students conducted by Kids Are People, Inc.

Service Gaps

Street and community outreach for at-risk youth is available only in Anchorage. Funding for this program expires in mid-2007.

Group health education/risk reduction sessions using a curriculum with evidence of effectiveness are available in substance abuse treatment programs and youth detention facilities conducted mostly by staff, but augmented in the urban centers by sessions conducted by CBOs funded by the state under the CDC cooperative agreement. Funding for the CBO activities expires in mid-2007.

Comprehensive sexuality education that includes information about contraception, safer sex and disease prevention methods is needed statewide. While HIV prevention education in the context of comprehensive health education is recommended by the Alaska Department of Education and Early Development for kindergarten through 12th grade, it is up to individual School Districts to set district requirements for health education. No school district in Alaska currently mandates HIV education. Abstinence only curricula promote abstinence as the only acceptable form of pregnancy and STD prevention. Comprehensive sexuality education programs promote abstinence as well as educating students about science-based methods of pregnancy and disease prevention.

Persons in Rural Areas or in Ethnic/Language Minority Populations

Indication of Need

In Alaska, some minority populations are disproportionately impacted by HIV/AIDS although the degree of disparity is less than is the case nationally for Blacks and Hispanics. Minority categories include geographic populations as well as those defined by race/ethnicity or language. True, there are fewer HIV/AIDS cases among persons residing in rural Alaska at time of first HIV diagnosis than among persons residing in urban centers at the time of first HIV diagnosis. Of the 118 HIV-only cases first reported between 2001 and 2005, 22 cases (19%) were in persons residing in a rural hub community or village at the time of diagnosis, whereas, 84 cases (71%) were residing in an urban center or sub-urban community at the time of diagnosis. In absolute numbers, there are fewer HIV/AIDS cases (both cumulative and in the most recent five years of HIV-only cases) among all persons in racial or ethnic minority groups combined than there are among Whites. However, an examination of rates of HIV/AIDS per 100,000 persons reveals the relative impact of these cases within categories of residence and race/ethnicity. The rate per 100,000 of HIV-only cases first diagnosed between 2001 and 2005 in persons residing in rural hubs or villages at time of diagnosis is comparable to the rate for cases in urban and sub-urban residents. Rates of HIV-only per 100,000 for cases first diagnosed in 2001 through 2005 are higher in Black men and women, Alaska Native men and women, Hispanic men, and Asian/Pacific Island men than rates for White men and women. (See Appendix A: Epidemiologic Profile).

While it is important to direct resources to locations and populations that represent the majority of cases, effort must also be directed to areas and sub-populations that experience a

disproportionate burden of HIV. The overall portfolio of funded interventions for the State must include, where feasible, interventions specifically designed for these disproportionately affected minority populations. Where interventions designed for a specific racial/ethnic minority (e.g. Brother to Brother or VOICES/VOCES) are not feasible due to small population, funded interventions must attend to the diversity within the intended participant group and incorporate the “Characteristics of Effective Interventions” (see Figure 8 in Chapter 5) with respect to cultural and language appropriateness of materials and staffing, and must make a concerted effort to recruit participants from minority populations in proportion to their representation in the group for which the intervention is intended. For example, interventions for MSM in a city should recruit participants to approximate the estimated demographics of MSM; an intervention in a correctional facility should recruit participants in proportion to the demographics of the incarcerated population.

Prevention Services

State-funded Interventions under the CDC Cooperative Agreement

The HIV/STD Program provides HIV partner services for all persons newly reported with HIV/AIDS and their sex and needle sharing partners.

HIV-specific Services Directly Funded by Federal Agencies

The Alaska Native Tribal Health Consortium (ANTHC) is funded through mid-2009 by CDC to conduct HIV prevention activities in Bethel and some villages in the Yukon-Kuskokwim Delta. ANTHC is also funded by the federal Health Resources and Services Administration (HRSA) for a Special Projects of National Significance (SPNS) for HIV prevention and linkage to care services in the Norton Sound region. The Yukon-Kuskokwim Health Corporation is funded by HRSA through mid-2007 to promote HIV testing, build capacity of providers to provide HIV testing, and to provide community education.

State-funded Services

HIV counseling and testing, and STD diagnosis and treatment are provided at most state-funded Public Health Nursing Centers and by public health nurses at tribal health clinics under PL93-638 contracts with the state. Public health nurses also work closely with HIV/STD Program staff to carry out partner notification activities in rural communities. Clients in substance abuse treatment programs statewide receive HIV information and access to HIV and STD testing. The Division of Behavioral Health requires that all individuals entering substance abuse treatment have access to infectious disease screening, risk reduction education, counseling, and medical services, including diagnosis and treatment for HIV.

Alaska Native Regional Health Corporations

Involvement with HIV prevention varies by Alaska Native health corporation. In some regions, health education and behavioral health programs incorporate HIV prevention education. Some health corporations are training Community Health Aides/Practitioners (CHA/P) to conduct HIV testing, and the 2006 CHA/P manual includes guidelines on prevention counseling and HIV testing. Physicians and mid-level practitioners at sub-regional clinics or itinerating to village clinics may provide HIV counseling and testing. Currently the ANTHC Ryan White EIS Program has case managers at Alaska Native health corporations in Anchorage, Bethel,

Fairbanks, Juneau and Sitka. Case managers include prevention counseling and medication adherence counseling with their HIV-positive clients.

Service Gaps

HIV-specific prevention interventions are lacking in rural regions except where federally-funded special projects are being conducted. Depending on the region receiving funding for special projects, only the regional hub and some self-selected villages are participating.

Social and demographic characteristics of rural communities make implementing HIV prevention interventions for a specific behavioral risk population (e.g., MSM, IDU, heterosexual women at high risk) especially challenging. Individual-level interventions that target all or multiple behavioral risk populations, such as HIV counseling and testing, HIV and STD partner services, and one-on-one counseling with HIV-positive persons, are more feasible.

Integration of HIV prevention information into existing programs for persons at increase risk, such as group presentations at substance abuse treatment programs, is more feasible than group sessions for members of a single behavioral risk population.

Media-based health communication/public information activities are needed to raise awareness about HIV, to de-stigmatize HIV testing, to direct people to prevention resources, and to foster a compassionate response to persons with HIV. Raising awareness about the risk of HIV infection is a challenge in low prevalence states like Alaska. This is particularly true for rural Alaska where HIV is a lower priority than other pressing concerns. Stigma attached to having HIV and fear of disclosure are impediments to getting tested and, if HIV positive, seeking care.

Aside from Alaska Native health corporations, there are no organizations serving racial/ethnic and linguistic minority populations that are currently funded to conduct HIV-specific interventions. Community groups and organizations connected to minority populations that are disproportionately impacted by HIV need support and encouragement to include HIV prevention into the services they provide, to partner with funded HIV prevention programs, and to develop the capacity to compete successfully for HIV prevention funding.

Chapter 4

Priority Populations



2007-2009 Alaska HIV Prevention Plan

Chapter Four: Priority Populations

According to the CDC HIV Prevention Community Planning Guidance, “Target populations should include populations in which the most HIV infections are occurring or populations with the highest HIV incidence” and should consider “the risk behaviors and prevention needs of People Living with HIV/AIDS (PLWHA).” The HPPG carried out an evidence-based process to determine the highest priority populations with prevention needs in Alaska. The HPPG based their decisions on data from the epidemiologic profile (see Appendix A) and the community services assessment (see Chapter 3) and their knowledge of Alaskan communities. Appendix B contains tables with the factors and weighting that were used in the preliminary prioritizing based on HIV and STD data.

The eight priority populations for the *2007-2009 Alaska HIV Prevention Plan* in order are:

- 1.HIV Positive Persons;
- 2.Men Who Have Sex With Men (MSM);
- 3.Injection Drug Users (IDU);
- 4.Heterosexual women at increased risk;
- 5.Heterosexual men at increased risk;
- 6.Incarcerated persons;
- 7.Youth at increased risk; and
- 8.Persons in rural areas or in ethnic/language minority populations.

**“Priority setting for target populations must address populations for which HIV prevention will have the greatest impact.”
CDC 2003**

The following section presents the prioritized populations and summarizes the key reasons for prioritization.

#1 HIV-Positive Persons

HIV-positive individuals are an important population for both preventing further transmission of HIV infection and for preventing co-infection with other STDs or blood borne pathogens. Fortunately, the availability of increasingly effective therapies for HIV disease has contributed significantly to longer, healthier lives for persons with HIV. It is critical to increase the proportion of infected individuals who are aware of their HIV status and who participate in medical care, treatment, and other services supportive of primary and secondary prevention. Primary prevention refers to helping persons avoid contracting HIV infections and secondary prevention refers to reducing or alleviating adverse consequences among persons who are living with HIV disease. A high proportion of persons who learn that they are HIV-infected adopt behaviors that are known to reduce the risk for transmitting HIV (CDC, 2000). However, data from national studies and HIV partner notification services conducted by the State HIV/STD Program indicate the presence of risk behavior among some HIV-positive persons.

#2 Men Who Have Sex With Men (MSM)

The transmission category of male-to-male sexual contact (among homosexual or bisexual males) comprised 36% of all recent (2001 through 2005) cases of HIV without AIDS in Alaska, and 53% of all recent cases in males. When MSM/IDU cases are included, MSM comprise 56% of recent cases in males. MSM remains the most prevalent risk factor for males of all races/ethnicities. The proportions of recent HIV cases in Alaska Native, Black, and Hispanic males are greater than the proportions of these populations in HIV/AIDS cases diagnosed in males earlier in the epidemic. Between September 2004 and December 31, 2005, 26 cases of early syphilis were reported in Alaska, 22 (85%) were in males and 13 (50%) were in MSM. Among these case patients and their sexual partners, individuals were additionally diagnosed with chlamydia, gonorrhea, hepatitis B, hepatitis C, herpes, human papilloma virus, and HIV. These occurrences confirm risk behavior and indicate the need for prevention services within the MSM community.

#3 Injection Drug Users (IDU)

Injection drug use is an important risk behavior for HIV infection and affects people in all areas of Alaska. Injection drug use as a single transmission category accounted for 18% of all recent HIV cases (21% of cases in females and 19% of cases in males, including MSM-IDU transmission). Recent cases are defined as cases of HIV infection without AIDS diagnosed from 2001-2005. Focus groups with IDU in Anchorage in 2002 indicated a need for syringe access, but no syringe exchange program has been initiated and sustained. There is an active syringe exchange program in Fairbanks.

#4 Heterosexual Women at Increased Risk

Heterosexual contact was the transmission category for 28% of all recent HIV cases, and accounted for 54% of all recent cases in females. (Recent cases are defined as cases of HIV infection without AIDS diagnosed from 2001-2005.) The proportions of recent HIV infections in Alaska Native and Black women are greater than their proportionate representations in the Alaska population: Alaska Native females comprised 28% of recent HIV cases compared to 18% of the total Alaska female population. Black females comprised 13% of recent HIV cases and 4% of the female population. Hispanic females comprised 3% of recent HIV cases and 4% of the female population. Focus group and interview data from Alaska Native women with a history of recent drug use indicate sexual risk behaviors.

#5 Heterosexual Men at Increased Risk

Among cases of HIV diagnosed in men between 2001 and 2005 reported in Alaska, 15% were among men for whom the only disclosed risk factor was sexual contact with an HIV-positive woman, or who came from a country with a high prevalence of heterosexually transmitted HIV. Men in minority ethnic populations, especially Alaska Natives and Blacks, are overrepresented in HIV and STD case rates in Alaska. Since some STDs are often asymptomatic in men, STD partner notification is an important service for men exposed to an STD who are not aware of their infection. STD partner notification also facilitates prevention counseling and HIV testing for those for whom it is appropriate. Results of the investigation of a syphilis outbreak in Alaska between 2004 and 2006 indicate an overlap in the sexual and drug using networks of MSM and non-gay identified men who are involved in methamphetamine production and use. Men who do not identify as MSM or IDU appear to have a low perception of HIV risk and are unlikely to seek prevention interventions including HIV counseling and testing. Rather, HIV prevention efforts must be incorporated into services reaching men at increased risk such as STD clinics, substance abuse treatment programs, correctional facilities and community residential centers (pre-release programs), and services for homeless men.

#6 Incarcerated Persons

Nationally, the prevalence of HIV in incarcerated populations is estimated to be nearly five times that of the general population. According to the U.S. Bureau of Justice, 2.0% of State prison inmates and 1.1% of Federal prison inmates were HIV-positive at the end of 2003. Incarceration for drug related offenses may explain much of this disproportion. Similarly, because of drug use, the prevalence of Hepatitis B and C is disproportionately high among incarcerated persons. In Alaska, 0.5% of the incarcerated population in 2002 was HIV-positive. In 2002, 10% of the incarcerated population in Alaska was convicted on a charge involving a controlled substance. Although not implicated in Alaska cases to date, there is a potential risk of HIV transmission in incarcerated settings through unprotected sex, sharing drug equipment, and non-sterile piercing and tattooing equipment. Correctional settings provide an opportunity to deliver prevention interventions to help inmates reduce risk behaviors while incarcerated and upon release into the community, and to educate about testing for HIV, STD, and viral Hepatitis. For the purpose of the recommendations in this *Plan*, incarcerated persons include inmates in correctional centers, residents of Department of Corrections community residential facilities (half-way houses), and recently incarcerated persons on probation or parole.

#7 Youth at Increased Risk

The population of youth at increased risk was prioritized on the basis of data indicating a high prevalence of sexual risk behaviors and the premise that safer behavior patterns learned in youth may continue to serve individuals well as they become adults. Even though HIV is uncommon in youth in Alaska, risk behavior is indicated by the occurrence of sexually transmitted diseases and pregnancy. The 2005 rate of chlamydia in youth aged 15-19 in Alaska was especially high in young women, at 4,145 per 100,000 females (1,085 cases), while the rate in young men was 965 per 100,000 males (269 cases). Rates in both genders were even higher in persons aged 20-24. These rates compare to overall chlamydia rates in the Alaska population in females of 911 per 100,000 females and in males of 429 per 100,000 males, with Alaska having among the highest chlamydia rates in the United States in 2005. Gonorrhea is much less common in Alaska, especially in very young persons, but there were 85 cases in females aged 15-19 years and 25 cases in males in this age group reported in 2005.

Teen pregnancy rates also indicate unprotected sex. There were 1,499 pregnancies reported in females aged 15-19 in 2004. Pregnancy rates decreased in youngest age group (15-17 years) but increased in all other age groups in 2004 compared to 2003.]

Data from the Alaska Youth Risk Behavior Survey (YRBS) indicate reduction in some risk behaviors over time, while also indicating the continuing presence of risk. YRBS data show a decrease from 1995 to 2003 in the number of high school students who report ever having sexual intercourse. There was a decrease from 48% to 40% in boys and from 46% to 40% in girls. Condom use among sexually active students has increased since 1995. In 2003, 62% of sexually active high school students reported having used a condom during the last instance of sexual intercourse. This is an increase of 7% for boys and 11% for girls. Use of alcohol or drugs before last sexual intercourse was reported by 25% of sexually active teens. This represents a slight decrease for boys since the 1995 survey. Among all students in 2003, 75% reported ever using alcohol, a decrease from 80% in 1995; 39% reported current use of alcohol, a decrease from 48% in 1995; and 27% reported binge drinking in the 30 days prior to the survey, a decrease from 31% in 1995.

#8 Persons in Rural Areas or in Ethnic/Language Minority Populations

There are fewer HIV/AIDS cases among persons residing in rural Alaska at time of first HIV diagnosis than among persons residing in urban centers at the time of first HIV diagnosis. Of the 118 HIV only cases first reported between 2001 and 2005, 22 cases (19%) were in persons residing in a rural hub community or village at the time of diagnosis, whereas, 84 cases (71%) were residing in an urban center or sub-urban community at the time of diagnosis. However, the rate per 100,000 of HIV-only cases first diagnosed between 2001 and 2005 in persons residing in rural hubs or villages at time of diagnosis is comparable to the rate for urban and sub-urban cases. Rural regions have disproportionately high rates of STD, especially chlamydia.

In absolute numbers, there are fewer HIV/AIDS cases (both cumulative and in the most recent five years of HIV-only cases) among all persons in racial or ethnic minority groups combined

than there are among Whites. However, an examination of rates of HIV/AIDS per 100,000 persons reveals the relative impact of these cases within categories of race and ethnicity. Rates of HIV-only per 100,000 for cases first diagnosed in 2001 through 2005 are higher in Black men and women, Alaska Native men and women, Hispanic men, and Asian/Pacific Island men than rates for White men and women. Alaska Natives and Blacks are disproportionately impacted by chlamydia and gonorrhea.

HIV prevention services are limited to non-existent in rural areas due to small, widely dispersed populations and limited health infrastructure. In urban and rural areas alike HIV prevention information and services for non-English speakers are similarly very limited. Although currently the number of cases of HIV in Hispanics in Alaska is small, the proportion of cumulative cases of HIV in Hispanics (7%) is greater than the proportion of Hispanics in the state (4%). Given that Hispanics moving to Alaska are coming from areas of the U.S. where the HIV prevalence in Hispanics is disproportionately high and from some countries with high HIV prevalence, the need for Spanish language information and services will predictably increase.

Chapter 5

Interventions



2007-2009 Alaska HIV Prevention Plan

Chapter Five: Interventions

Information on Effective Interventions

In selecting appropriate interventions specific to each priority population, the HPPG considered consistency with the national strategy to identify previously undiagnosed HIV infection and to recommend interventions that have the potential to prevent the greatest number of new

“The set of prevention interventions or activities for prioritized target populations should have the potential to prevent the greatest number of new infections.”

CDC 2003

infections. This chapter provides information about interventions with evidence of effectiveness and describes the interventions that were considered when recommendations were identified for the *2007-2009 Alaska HIV Prevention Plan*. Research on the effectiveness of prevention interventions is available from published studies on HIV prevention projects that have been scientifically evaluated and shown to be effective in reducing risk behaviors associated with HIV transmission. In developing recommendations for the *2007-2009 Alaska HIV Prevention*

Plan, the Alaska HPPG considered only those interventions that have a sound basis in social and behavioral science theory and have demonstrated effectiveness in influencing behavior change, or are recommended by CDC as an essential component of a comprehensive HIV prevention program.

Core Theories of Behavior Change

Behavior change theory describes what factors or relationships influence behavior and/or environment, and provides direction on how to impact them. Theories used in HIV prevention are drawn from several disciplines, including psychology, sociology and anthropology. A theory becomes formalized when it is carefully tested with the results repeatable in a number of different settings, and generalizable to various communities (Goldman, 2001). HIV prevention interventions are informed by the following theories: Social Cognitive Theory/Social Learning Theory, Information, Motivation, Behavioral Skills, Stages of Change/Transtheoretical Model, Theory of Gender and Power, Diffusion of Innovation Theory, Social Action Theory, Theory of Reasoned Action, Health Belief Model, and Social Network Theory. Each prevention intervention for identified priority populations is based on behavioral and social science, outcome effectiveness, and/or has been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability. Behavioral science research has shown that a person is more likely to lower his or her risk of HIV infection if he or she:

- Believes that the advantages of making a change in behavior are greater than the disadvantages;
- Has formed a strong intention to change;
- Has the skills to perform the behavior;
- Believes he or she can make a change;
- Believes that the changed behavior will more likely produce a more positive than negative emotional response;
- Believes that the performance of the new behavior is consistent with his or her self-image;
- Perceives that there is social support for the behavior change; and
- Experiences no environmental barriers blocking the behavior change.

Characteristics of Effective Interventions

The HPPG has determined that it is important to build into all interventions the characteristics of effective HIV prevention interventions that have emerged from the years of prevention research and program experience. These “Characteristics of Effective Interventions” are listed in Figure 8.

Figure 8. Characteristics of Effective Interventions

Interventions should:

- have a clearly defined target population;
- have clearly defined objectives and implementation plan;
- be accessible and affordable to the target population, preferably taking the intervention to the intended population in the community or institutional settings;
- be based on sound behavioral science theory, focusing on factors that affect behavior change (skills, self-efficacy, expectation of positive response, consistency with self-image, perceived social norms, and reduction of external barriers);
- be based on intervention models scientifically evaluated with evidence of effectiveness or show evidence to support the expectation of effectiveness;
- be culturally competent and relevant to the targeted populations (i.e., consistent with norms, values, and traditions of the community);
- be appropriate for the developmental, age, and educational level of the intended population;
- be tailored to the gender and sexual orientation of the intended population;
- involve members of the target population in program design, implementation and evaluation;
- utilize personnel who reflect the cultural and linguistic characteristics of the intended audience to deliver the intervention; utilize members of the target population as peer educators;
- provide materials and deliver interventions in the primary language of the intended audience;
- focus on building and practicing skills (information alone is not enough), including harm reduction practices and communication, identifying triggers and coping with risk situations;
- provide, directly or by referral, risk reduction materials, minimally condoms;
- have ample duration and intensity to promote lasting behavior change (one time only interventions have limited effectiveness);
- be client-focused and tailored to client's stage of readiness, be non-judgmental, and be supportive of incremental change, recognizing that lapses are an expected part of the process of behavior change;
- be incorporated into services reaching persons at risk (e.g., drug and alcohol treatment, STD treatment); and
- have a mechanism in place for referring HIV-positive individuals to health care and support services.

For interventions to be implemented successfully, HIV prevention programs should:

- have an established relationship with the target population(s);
- have sufficient resources to accomplish their objectives;
- have flexibility to make mid-course modifications as necessary;
- be operated by an agency with adequate management capability, and administrative and board support for the interventions;
- provide ongoing training and development of staff and volunteers;
- provide support and supervision of staff and volunteers, including field-based observation;
- develop linkages with services reaching the same target populations to promote referrals; and
- evaluate interventions to assure that they are implemented as proposed and meeting objectives.

CDC's Diffusion of Effective Behavioral Interventions (DEBI) Project

The Diffusion of Effective Behavioral Interventions (DEBI) Project began in 1999 when the Centers for Disease Control and Prevention (CDC) published a *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* to respond to prevention service providers who requested science-based interventions that work (CDC, 2001). The DEBI Project was designed to bring science-based, community- and group-level HIV prevention interventions to state and local health departments and community-based service providers. The goal of the DEBI Project is to enhance the capacity to implement effective interventions at the state and local levels, to reduce the spread of HIV and STDs, and to promote healthy behaviors. DEBIs have been proven effective through research studies that showed positive behavioral (e.g., use of condoms; reduction in number of partners) and/or health outcomes (e.g., reduction in the number of new STD infections). Studies employed rigorous research designs, with both intervention and control groups, so that the positive outcomes could be attributed to the interventions. With input from the researchers, the materials necessary to implement the interventions have been packaged into user-friendly kits and standardized training are available from CDC funded capacity building providers. More detailed information about the DEBI project and interventions, including those that will be packaged and available in the future can be found online (AED, 2006). The following are brief summaries of the twelve science-based, effective interventions for HIV prevention identified in the DEBI Project at the time this *Plan* was written:

Healthy Relationships is a five-session, small-group intervention for men and women living with HIV/AIDS. It is based on Social Cognitive Theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills.

Holistic Health Recovery Program (HHRP) is a 12-session, manual-guided, group-level program for HIV-positive and HIV-negative injection drug users. The primary goals of HHRP are harm reduction, health promotion, and improved quality of life.

Many Men, Many Voices (3MV) is a six- or seven-session, group level STD/HIV prevention intervention for gay men of color. The intervention addresses behavioral influencing factors specific to gay men of color, including cultural/social norms, sexual relationship dynamics, and the social influences of racism and homophobia.

Mpowerment is a community-level intervention for young men who have sex with men. The intervention uses a combination of informal and formal outreach, discussion groups, creation of safe spaces, social opportunities, and social marketing to reach a broad range of young gay men with HIV prevention, safer sex, and risk reduction messages.

Popular Opinion Leader (POL) is a community-level intervention designed to identify, enlist, and train key opinion leaders to encourage safer sexual norms and behaviors within their social networks of friends and acquaintances through risk-reduction conversations.

Promise (also known as Community Promise) is a community-level HIV prevention intervention that relies on peer advocates to distribute role model stories of positive behavior change to members of the target population. The intervention is based on Stages of Change

and other behavioral theories, and can be implemented with various populations including IDUs, MSM, sex workers, and partners of high-risk individuals.

Real AIDS Prevention Project (RAPP) is a community mobilization program, designed to reduce risk for HIV and unintended pregnancy among women in communities at high risk by increasing condom use. This intervention relies on peer-led activities, including: stage based encounters, role model stories and brochures, community networking, referrals, safer sex discussions and condom distribution. RAPP is based on the transtheoretical model of behavior change.

Safety Counts is a client-centered intervention for users of illicit drugs that aims to reduce risk of becoming infected with or transmitting HIV and hepatitis viruses. It is a behaviorally focused, seven-session intervention, which includes both structured and unstructured psycho-educational activities in group and individual settings over four to six months.

Sisters Informing Sisters on Topics about AIDS (SISTA) is a group-level, gender- and culturally- relevant intervention, is designed to increase condom use with sexually active Black women. Five peer-led group sessions are conducted that focus on ethnic and gender pride, HIV knowledge, and skills training around sexual risk reduction behaviors and decision making. The intervention is based on Social Learning theory as well as the theory of Gender and Power.

Street Smart is a multi-session, skills-building program to help runaway and homeless youth, ages 11 to 18, to practice safer sexual behaviors and reduce substance use. Sessions address improving youths' social skills, assertiveness and coping through exercises on problem solving, identifying triggers, and reducing harmful behaviors. Agency staff also provide individual counseling and trips to community health providers.

Together Learning Choices (TLC) (also known as Teens Linked to Care) is an effective intervention for young people, aged 13 to 29, living with HIV, and it is delivered in small groups. This program helps young people living with HIV identify ways to increase use of health care, decrease risky sexual behavior and drug and alcohol use, and improve quality of life. Participants set goals regarding their health sexual relationships, drug use, and daily peace related to their daily habits and social routines. It emphasizes how contextual factors influence the ability to respond effectively to stressful situations, solve problems, and act effectively to reach goals. TLC is based on Social Action Theory.

VOICES/VOCES (Video Opportunities for Innovative Condom Education & Safer Sex) is a group-level, single-session video-based intervention designed to increase condom use among heterosexual Black and Hispanic men and women who visit STD clinics. Participants, grouped by gender and ethnicity, view an English or Spanish video on HIV risk behaviors and condom negotiation, take part in a facilitated discussion on barriers to and negotiation of condom use, and receive samples of condoms.

Procedural Guidance for Community-based Organizations

The *Procedural Guidance* was developed to summarize the best currently available science related to HIV prevention for community-based organizations. The *Procedural Guidance*

provides an outline for each strategy under the following subheadings: description of intervention; core elements, key characteristics, and procedures; resource requirements; recruitment; physical setting characteristics; necessary policies and standards; quality assurance; monitoring and evaluation; and key articles and resources. When selecting HIV prevention interventions/activities the HPPG used the draft *Procedural Guidance for Selected Strategies and Interventions for Community Based Organizations Funded Under Program Announcement 04064*, which was dated December 2003. In April 2006 an updated version of the *Provisional Procedural Guidance for Community Based Organizations* became available and the full text can be viewed online (CDC, 2006c). As well, the At-a-Glance version of the *Procedural Guidance* was disseminated as a companion document to the full-text *Procedural Guidance*. Together, these two documents are meant to provide the information needed to help organizations to select interventions best suited to the populations they intend to reach. The *Procedural Guidance* includes information about the aforementioned DEBI Project interventions. Below is a short summary of the activities, services, and strategies other than DEBIs listed in the *Procedural Guidance*.

Comprehensive Risk Counseling and Services (CRCS) for Persons at Very High Risk for HIV, formerly Prevention Case Management (PCM), aims to help clients who have multiple, complex psychosocial challenges and risk-reduction needs adopt and maintain risk-reduction behaviors. It provides intensive and ongoing client-centered HIV risk-reduction counseling, support, and it helps clients access other services. It helps clients initiate and maintain behavior change to prevent acquisition of HIV while addressing competing needs that may make HIV prevention a lower priority. CRCS for persons at very high risk informs and screens clients, helps them develop prevention strategies, delivers counseling sessions, and coordinates and follows up with other services provided to CRCS clients.

Comprehensive Risk Counseling and Services (CRCS) for Persons Living with HIV, formerly Prevention Case Management (PCM), aims to help clients who have multiple, complex psychosocial challenges and risk-reduction needs adopt and maintain risk-reduction behaviors. It provides intensive and ongoing client-centered HIV risk-reduction counseling, support, and it helps clients access other services. Priority is given to HIV-infected persons who are having, or are likely to have, difficulty initiating or sustaining practices that reduce or prevent the transmission of HIV while addressing competing needs that may make HIV prevention a lower priority. It addresses the relationship between HIV risk and other issues (e.g., substance abuse, mental health, social and cultural factors, and physical health).

HIV Counseling, Testing, and Referral (CTR) is a collection of activities designed to increase clients' knowledge of their HIV status; encourage and support risk reduction; and secure needed referrals for appropriate medical, prevention, and partner counseling and referral services. HIV CTR can be anonymous (client's name is neither known nor solicited) or confidential (client provides name). Clients can refer themselves or be referred to CTR, which can be accessed through clinics, dedicated sites, outreach, and other services.

Incorporating HIV Prevention into the Medical Care of Persons Living with HIV is a set of recommendations for using outpatient clinics and care providers to screen for HIV transmission risk behaviors and STDs, provide brief behavioral prevention interventions, and facilitate partner notification and counseling. The objectives are to reach a large number of HIV-infected persons, implement a safer-sex program, integrate HIV prevention into routine medical care, and involve

clinic staff in HIV prevention counseling. These objectives are accomplished by screening patients; providing brief behavioral risk-reduction interventions in the office and referring clients, if needed; and facilitating notification and counseling of sex partners and drug-using partners.

Partner Counseling and Referral Services (PCRS) is a public health strategy to control and prevent the spread of HIV and other STDs. PCRS is the practice of informing current and past partners that a person who is HIV-infected has identified them as a partner at risk (sex partner or injection-drug-equipment-sharing partner). PCRS advises these informed partners to have HIV counseling and testing. For partners who are not infected with HIV, PCRS provides an opportunity for intervention to prevent them from becoming infected; for partners who are found to be infected, it provides an opportunity to link them to medical evaluation, treatment, and other services and an opportunity for intervention to prevent transmission to others.

Rapid HIV Testing in Nonclinical Settings is HIV testing that can be performed in selected nonclinical settings and can provide results in 20 minutes, takes advantage of the benefits of outreach testing, increases the likelihood that tested persons receive their results, and requires confirmation if test results are positive. Rapid HIV Testing in nonclinical settings aims to increase knowledge of HIV status among many groups. By bringing testing into the community and providing test results quickly, rapid HIV testing can be used to reach groups in which HIV infection has been under diagnosed. Testing programs in nonclinical settings are more likely to reach members of some racial and ethnic minorities and persons at increased risk for HIV.

Routine HIV Testing of Inmates in Correctional Facilities is a service in which inmates are informed of the availability of free voluntary rapid HIV counseling and testing. The goal is to identify HIV infection among inmates who are unaware of their status or who have previous negative test results. Prevention and care services can then be provided to those who need them, during incarceration and after release. For those incarcerated for fewer than 30 days, routinely providing rapid HIV testing will increase the proportion tested and notified of their results before release.

Universal HIV Testing of Pregnant Women is an intervention to reduce perinatal transmission of HIV in the United States. It identifies pregnant women for whom antiretroviral and obstetric interventions can reduce the risk of having a HIV-infected baby. There are two approaches to offering HIV testing to pregnant women: 1) opt-in, in which pregnant women are given pretest counseling and must specifically consent, usually in writing, to an HIV test, and 2) opt-out, in which pregnant women are notified that a HIV test will be included in the standard battery of prenatal tests and that they may decline testing.

Compendium of HIV Prevention Interventions with Evidence of Effectiveness

The *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* was compiled by CDC to include evaluated projects with demonstrated effectiveness in November 1999 and was revised in August 2001. All interventions selected for this *Compendium* came from behavioral or social studies that had both intervention and control/comparison groups and positive results for behavioral or health outcomes. CDC required designs with control/comparison groups so that successful results could be attributed to the interventions. To

meet the ongoing need for current information about what works in HIV prevention, this *Compendium* is updated periodically. The *Compendium* provides state-of-the-science information about interventions with evidence of reducing sex- and/or drug-related risks, and the rate of HIV/STD infections. The full text of the *Compendium* can be found online (CDC, 2001). The following are the prevention interventions listed in the *Compendium*:

 Drug Users	<p><u>ACDP Research Group, 1999, AIDS Community Demonstration Projects¹</u> <u>Des Jarlais, et al., 1992, AIDS/Drug Injection Prevention</u> <u>El-Bassel & Schilling, 1992, Skills Building</u> <u>Magura, et al., 1994, Intensive AIDS Education in Jail¹</u> <u>McCusker, et al., 1992, Informational and Enhanced AIDS Education</u></p>
 Heterosexual Adults	<p><u>ACDP Research Group, 1999, AIDS Community Demonstration Projects¹</u> <u>Cohen, et al., 1991, Condom Skills Education</u> <u>Cohen, et al., 1992, Group Discussion Condom Promotion</u> <u>DiClemente & Wingood, 1995, Social Skills Training</u> <u>Hobfoll, et al., 1994, Reducing AIDS Risk Activities</u> <u>Kamb, et al., 1998, Project RESPECT</u> <u>Kelly, et al., 1994, Cognitive-Behavioral Skills Training Group</u> <u>Lauby, et al., 2000, Women and Infants Demonstration Projects (WIDP)</u> <u>O'Donnell, et al., 1998, Video Opportunities for Innovative Condom Education and Safer Sex (VOICES/VOCES)</u> <u>Wenger, et al., 1991, HIV Education, Testing, and Counseling</u></p>
 Men Who Have Sex With Men	<p><u>ACDP Research Group, 1999, AIDS Community Demonstration Projects¹</u> <u>Kegeles, et al., 1996, Mpowerment Project</u> <u>Kelly, et al., 1989, Behavioral Self-Management and Assertion Skills</u> <u>Kelly, et al., 1991, Popular Opinion Leader (POL)</u> <u>Valdiserri, et al., 1989, Small Group Lecture Plus Skills Training</u></p>
 Youth	<p><u>ACDP Research Group, 1999, AIDS Community Demonstration Projects¹</u> <u>Jemmott, et al., 1992, Be Proud! Be Responsible!</u> <u>Kirby, et al., 1991, Reducing the Risk</u> <u>Magura, et al., 1994, Intensive AIDS Education in Jail¹</u> <u>Main, et al., 1994, Get Real about AIDS 1992</u> <u>Rotheram-Borus, et al., 1997, StreetSmart</u> <u>Stanton, et al., 1996, Focus on Kids</u> <u>St. Lawrence, et al., 1995, Becoming a Responsible Teen (BART)</u></p>

There are two interventions, Street and Community Outreach and Be Proud! Be Responsible/Making Proud Choices!, which are listed in the *Compendium* that are not DEBIs, but that have been successfully implemented in Alaska in prior years.

Street and Community Outreach has model programs or studies on effectiveness in the *Compendium*. The HPPG considered Street and Community Outreach as an intervention type that is grounded in behavior change theory, scientifically evaluated, and shown to be effective. Street and Community Outreach aims to reduce HIV infection through decreasing unsafe sexual behaviors, increasing condom use, and delaying sexual activity. Street and Community Outreach also aims to reduce sharing of injection equipment, increase clean syringe access and bleach cleaning, and increase HIV counseling and testing. Paid or volunteer peer outreach workers, who are cultural and linguistic representatives of the target population, provide a sustained and regular presence in the community. Efforts are focused on specific areas of a community frequented by persons who engage in risk behavior. Outreach workers provide risk reduction information and supplies, such as condoms and lubricant, injection harm reduction equipment as applicable, and information on HIV Health Education and Risk Reduction (HE/RR) and HIV Counseling and Testing (CT) resources. Outreach workers facilitate personal risk perception and risk assessment and provide skills training to outreach contacts. Messages of peer and community support for safer behaviors, and specific referrals to more intensive risk reduction resources are provided as appropriate.

Making Proud Choices! is an adaptation and extension of the original *Be Proud! Be Responsible!* curriculum in that it integrates STD, HIV and pregnancy prevention. It is an eight-module curriculum that provides young adolescents with the knowledge, confidence, and skills necessary to reduce their risk of sexually transmitted diseases (STDs), HIV, and pregnancy by using condoms if they choose to have sex. The goal of Making Proud Choices! is to empower young adolescents to change their behavior by drawing upon three theories: the Social Cognitive Theory, the Theory of Reasoned Action and its extension, the Theory of Planned Behavior.

Additional HIV Prevention Interventions/Activities

Additional HIV prevention intervention/activities were considered by the HPPG that were not listed in the DEBI Project, *Procedural Guidance*, or the *Compendium*. Each of these intervention types has examples of projects employing the intervention that were grounded in behavior change theory and had been scientifically evaluated and shown to be effective, or they are interventions recommended by CDC as an important component of comprehensive HIV prevention services.

Targeted Health Communication/Public Information (HC/PI) is an intervention designed for any specified target population. There are four prevention goals: 1) encourage persons at risk to seek HIV counseling and testing; 2) raise awareness and dispel myths about HIV/AIDS; 3) influence community norms in support of safer behavior; and 4) support individual efforts for personal risk reduction. Culturally, linguistically, and community appropriate messages are used to raise awareness, educate about risk reduction, and to influence community norms. Messages are dispersed through the use of broadcast (television, radio), electronic (websites, email, list serves), print media, and hotlines that are accessed by the specific target population. A study by the Rand Corporation applied a mathematical model to the cost of HIV prevention interventions and national data on HIV risk-group size and HIV prevalence. The optimal allocation of HIV prevention activities involved a combination of intensive interventions for high-prevalence populations and inexpensive large-scale interventions for lower-prevalence populations (Cohen, et al, 2005). Inexpensive large-scale interventions, such as HC/PI could appropriately address Alaska's lower-prevalence populations.

Syringe Exchange is an intervention designed for Injection Drug Users (IDU) with the following prevention goals: reduce sharing of injection equipment; reduce unsafe sexual behaviors, and increase HIV counseling and testing. The HPPG recognizes that syringe exchange is an intervention that cannot be supported with federal funds, but considers it as an intervention with evidence of effectiveness. This intervention involves paid or volunteer peer outreach workers who are cultural and linguistic representatives of the target population and who have a sustained and regular presence in the community. Volunteers provide clean new syringes, needles, and other sterile injection drug equipment in exchange for used needles, as well as, referrals to drug treatment, methadone maintenance programs, and other services to help users reduce their drug use. Volunteers may also provide risk reduction information and supplies, such as condoms, lubricant, and information on HIV counseling and testing facilitates. Syringe exchange addresses two components of theoretical factors affecting HIV risk behavior – perceived social norms for safer behavior and reduced environmental barriers. Research on the effectiveness of syringe exchange has been summarized and published by the National Research Council, Institute of Medicine (1995).

Sexually Transmitted Disease (STD) Testing, Treatment, and Partner Notification Services is an intervention designed to test and treat STDs as an effective approach to reducing the likelihood of HIV transmission, if an exposure were to occur (Fleming and Wasserheit, 1999). Consistent efforts to locate, counsel, test, and treat exposed sexual partners are critical to reducing STD transmission, especially since STD symptoms may be absent or ignored. Infection with STD indicates unprotected sexual intercourse, which is also a risk behavior for HIV infection. Studies have shown that persons infected with STD are more likely to transmit HIV, if

infected, and more susceptible to HIV infection, if exposed and uninfected. HIV infection has been most closely associated in the U.S. with syphilis and gonorrhea infections in heterosexual populations in the Southeast United States and with syphilis and gonorrhea among men who have sex with men in a number of urban settings. An association between HIV and chlamydia infection is biologically plausible but has not been well explored.

Compared to other U.S. states, Alaska has a relatively low prevalence of HIV infection, a gonorrhea rate slightly below the average rate for the U.S. as a whole, and a high rate of chlamydia infection (this may be due in part to increased public health efforts to detect infections). Infectious syphilis, once rare in Alaska, re-emerged in recent years. An outbreak that began late in 2004 had resulted in 26 infectious syphilis cases reported through December, 2005. New cases continued to be reported in 2006. A large proportion of these cases occurred in MSM, and a significant proportion of those infected were also HIV positive. Some cases reported in 2005 and 2006 were also associated with methamphetamine use.

With the exception of syphilis, concurrent (co-) infection with two STDs or with HIV and another reportable STD are uncommon in Alaska. This indicates that individuals' sexual networks differ and that certain infections are more common in some networks than others. Since having a STD indicates risk behavior (unprotected sex, multiple partners), persons with STDs and their partners are candidates for prevention counseling and potentially for HIV testing. Because some STDs are so common, because STD infection facilitates HIV transmission, and because the number of persons living with HIV increases each year (since infection is lifelong), activities to reduce STDs infection rates (especially gonorrhea and syphilis since they tend to occur in individuals with the highest risk sexual networks) have a role in overall efforts to reduce HIV transmission.

HIV Counseling and Testing through Social Networks is a programmatic, peer-driven, recruitment strategy to reach the highest risk persons who may be infected but unaware of their status. This technique is accomplished by enlisting newly and previously diagnosed HIV-positive and high-risk-negative recruiters on an ongoing basis and providing HIV CTR to people in their networks. The use of social networks is a recruitment strategy whereby public health services are disseminated through the community by taking advantage of the social networks of persons who are members of the community. The strategy is based on the concept that individuals are linked together to form large social networks, and that infectious diseases often spread through these networks. The primary goal of a social network strategy is to identify persons with undiagnosed HIV infection within various networks and link them to medical care and prevention services. More information can be found in the Interim Guide for HIV Counseling, Testing, and Referral Programs titled, *Social Networks Testing: A Community-Based Strategy for Identifying Persons with Undiagnosed HIV Infection* (CDC 2006d).

It is appropriate and recommended that in adapting any of these interventions for implementation in Alaska, programs tailor the model, curriculum and materials to the intended target population and location. However, adaptations must retain the essential components of the model and fidelity to the underlying theory.

Selecting Interventions

For recommendation in the *2007-2009 Alaska HIV Prevention Plan*, the Alaska HPPG reviewed the information on the interventions that have a theoretical basis and evidence of effectiveness or are strongly recommended by CDC. In addition, the HIV/STD Program staff provided an assessment of the advantages and drawbacks of the evidence based DEBIs and other CDC-recommended interventions. This assessment was based on the experience of the health department and local community based organizations with implementing selected DEBIs in Alaska over the past three to five years. The HIV/STD Program identified advantages and drawbacks of the DEBIs in general, and then reviewed for the HPPG the challenges for implementing each of the specific DEBIs in Alaska. The drawbacks are by no means unique to Alaska, but many are related to characteristics of Alaska – relatively small population, relatively low HIV prevalence and limited resources for HIV prevention. The following are the general advantages and drawbacks of DEBIs for implementation in Alaska.

Advantages and Drawbacks of DEBIs

Advantages

- Interventions are based on behavior change theory;
- Interventions have evidence of effectiveness from rigorous evaluation research;
- Essential core elements are clearly identified;
- Packaged materials and curriculum are available; and
- National, standardized training for facilitators has been developed.

Drawbacks

The drawbacks or limitations of the DEBIs have to do with two major issues: (1) the applicability/feasibility of implementing them in Alaska and with the current level of funding; and (2) the availability of training and curricula.

1. Applicability/Feasibility

- Each DEBI was developed for a specific target population defined by risk factor and/or demographics; adapting a DEBI for a different population takes considerable resources and expertise.
- DEBIs were developed as research projects with far greater resources for implementation than are available to CBOs. The research projects had more staff, more highly trained staff, higher pay for staff, and higher incentives for participants than can be replicated locally.
- DEBIs were developed and tested in cities with specific community features (for example, gay bars, housing projects, concentrated ethnic neighborhoods) and with larger populations and higher HIV prevalence than Alaska. Recruiting the intended population and achieving fidelity to the model are challenging where the conditions of the original model are not present.

- Many DEBIs involve multi-session groups. It is more difficult to recruit and retain participants for multi-session groups than for briefer, more spontaneous and less intensive interventions such as outreach.
- The time lag between research and diffusion of a model intervention results in models and materials being out of date by the time they are ready for implementation. Updating interventions takes resources and expertise.

2. Training and Materials

- The national trainings and distribution of packaged materials have lagged behind the promotion of the DEBI models.
- National trainings are conducted in the contiguous United States. Sending staff from Alaska is costly. CBO staff turnover adds to the cost of training and creates interruptions in implementation of a DEBI.
- Slots in the national trainings have been limited and health departments and their grantees have been a lower priority than CBOs directly funded by CDC.
- When implementing a DEBI that relies heavily on volunteers, a CBO has to have the resources to support frequent training in the intervention due to volunteer turnover.
- Evaluation measures used for the original research projects are too comprehensive for CBO use; brief evaluation measures have not yet been developed for the DEBIs.

Additional Considerations for Selecting Interventions

Based on the local experience with implementing DEBIs and other CDC-recommended interventions in Alaska, the HIV/STD Program provided the following suggestions for developing recommendations for interventions.

- Recommend specific intervention models: The previous Plan recommended intervention *types* such as group health education/risk reduction, rather than naming specific DEBI models. After three to five years of local experience with implementing DEBIs and with the increased availability of DEBI materials, there is better information on which to make specific recommendations.
- Recommend a mix of interventions that maximize the impact of available (and declining) resources: A recent Rand Corporation study on cost-effective allocation of HIV prevention funds (Cohen 2005) recommended a combination of intensive, individually focused interventions for HIV-positive persons and partners (partner notification services); intensive efforts for the higher prevalence populations of MSM and IDU (community mobilization and needle exchange); *and* inexpensive larger scale interventions such as condom distribution and mass media campaigns for lower-prevalence populations.

- Emphasize interventions that reach individuals most likely to have HIV or be at highest risk, with targeted one-on-one interventions. Recommend fewer group HE/RR interventions for persons not known to be HIV-positive. Experience has shown that recruitment and retention of groups of persons in the intended priority population is difficult and that more generalized groups, such as women in substance abuse treatment, often include many persons not necessarily at high risk.
- Recommend a smaller portfolio of interventions. Whereas the HIV/STD Program has been an enthusiastic “early adopter” of DEBIs because of the advantages of interventions with well-researched evidence of effectiveness, three to five years of experience with DEBIs has provided a better understanding of the challenges of implementing these interventions in a low HIV prevalence state with relatively small and dispersed priority populations. With fewer intervention models to support, the HIV/STD Program can better meet the training needs for grantees and thereby reduce CBOs’ costs and reduce program interruptions due to staff turnover, as well as provide quality assurance and technical assistance for grantees.
- Include language in the recommendations that leaves the door open for other interventions with evidence of effectiveness beside those specified so as to accommodate:
 - an applicant for state prevention funding that presents a good justification and work plan for doing an evidence-based intervention not specified in the Plan;
 - other DEBIs or CDC-recommended interventions that come out during the three years covered by the Plan; and
 - organizations seeking funding from other sources that require reference to the HIV prevention plan.

Chapter 6

Recommendations



2007-2009 Alaska HIV Prevention Plan

Chapter Six: Recommendations

HIV Prevention Goals

This chapter contains recommendations for a mix of prevention activities and interventions that are science-based and appropriate for each prioritized target population. The recommendations support the following HIV prevention goals:

1. **Increase the number of HIV-infected persons who know their HIV status.** Strategies for doing so include: offering HIV testing in conjunction with partner notification services to persons potentially exposed to HIV; providing HIV testing services in sites reaching persons at increased risk; encouraging HIV testing, when indicated, as part of routine medical care; and supporting use of testing technologies acceptable to patients and appropriate to settings.
2. **Reduce HIV transmission to prevent new infections.** Strategies for doing so include early case identification through providing notification, testing, and prevention counseling for sex and needle-sharing partners of infected persons; facilitating diagnoses and treatment of STDs in persons with HIV infection; providing targeted behavior change interventions for persons with HIV infection and their partners; facilitating infected persons' participation in medical care and supportive services; and encouraging routine incorporation of prevention into medical care for HIV-positive persons.
3. **Reduce HIV risk behavior and co-factors** by providing targeted behavior change interventions for HIV-negative persons and persons of unknown HIV status who have behavioral risk factors for HIV infection, promoting community norms for adopting safer behaviors, and providing STD partner services.
4. **Reduce the number of HIV-positive persons that progress to AIDS** by linking persons with HIV infection to medical care and support services.

HIV Prevention Recommendations

The Alaska HIV Prevention Planning Group recommends that the full range of comprehensive HIV prevention program activities set forth in CDC guidelines be conducted in Alaska. Recommended prevention interventions are, to the greatest extent possible, science-based with evidence of effectiveness for the specified priority populations.

Recommendations for interventions and supporting activities are organized by priority population. These are followed by overall recommendations for capacity building, needs assessment, evaluation, and other health department activities necessary for a comprehensive HIV prevention program.

Interventions Specific to Priority Populations

Interventions recommended for each priority population and the corresponding prevention goals are listed below. Populations are listed in order of priority. The “Characteristics of Effective Interventions” (see Figure 8 in Chapter Five) apply to all interventions listed. Following the recommended interventions is a chart that summarizes the priority populations by recommended interventions.

HIV-Positive Persons	
Recommended Interventions	Prevention Goal
Partner Counseling and Referral Services (PCRS)	1, 2, 3
STD Testing and Partner Services	2, 3
Individual Prevention Counseling in Conjunction with Medical Care	2, 4
Comprehensive Risk Counseling Services (CRCS)	2, 4
Healthy Relationships	2
Other interventions with evidence of effectiveness or recommended by CDC, that are designed for HIV-positive persons, and for which there are curricula, guidelines, materials and nationally available training for facilitators.	2

Men Who Have Sex With Men (MSM)	
Recommended Interventions	Prevention Goal
Partner Counseling and Referral Services (PCRS)	1, 2, 3
HIV Counseling and Testing (HIV CT)	1, 3
HIV Counseling and Testing through Social Networks	1, 3
STD Testing and Partner Services	2, 3
Mpowerment	3
Other interventions with evidence of effectiveness or recommended by CDC, that are designed for men who have sex with men, and for which there are curricula, guidelines, materials and nationally available training for facilitators.	3

Injection Drug Users	
Recommended Interventions	Prevention Goal
Partner Counseling and Referral Services (PCRS)	1, 2, 3
HIV Counseling and Testing (HIV CT)	1, 3
HIV Counseling and Testing through Social Networks	1, 3
STD Testing and Partner Services	2, 3
Syringe Exchange	2
Street and Community Outreach	3
Other interventions with evidence of effectiveness or recommended by CDC, that are designed for injection drug users, and for which there are curricula, guidelines, materials and nationally available training for facilitators.	3

Heterosexual Women at Increased Risk	
Recommended Interventions	Prevention Goal
Partner Counseling and Referral Services (PCRS)	1, 2, 3
HIV Counseling and Testing (HIV CT)	1, 3
HIV Counseling and Testing through Social Networks	1, 3
Street and Community Outreach	3
STD Testing and Partner Services	2, 3
Other interventions with evidence of effectiveness or recommended by CDC, that are designed for heterosexual women at increased risk, and for which there are curricula, guidelines, materials and nationally available training for facilitators.	3

Heterosexual Men at Increased Risk	
Recommended Interventions	Prevention Goal
Partner Counseling and Referral Services (PCRS)	1, 2, 3
HIV Counseling and Testing (HIV CT)	1, 3
HIV Counseling and Testing through Social Networks	1, 3
Street and Community Outreach	3
STD Testing and Partner Services	2, 3
Other interventions with evidence of effectiveness or recommended by CDC, that are designed for heterosexual men at increased risk, and for which there are curricula, guidelines, materials and nationally available training for facilitators.	3

Incarcerated Persons	
Recommended Interventions	Prevention Goal
Partner Counseling and Referral Services (PCRS)	1, 2, 3
HIV Counseling and Testing (HIV CT)	1, 3
Single Session Group Presentations Connected to Testing	1, 3
STD Testing and Partner Services	2, 3
Other interventions with evidence of effectiveness or recommended by CDC, that are designed for incarcerated persons, and for which there are curricula, guidelines, materials and nationally available training for facilitators.	3

Youth at Increased Risk	
Recommended Interventions	Prevention Goal
STD Testing and Partner Services	3
Street and Community Outreach	3
Making Proud Choices!	3
Other interventions with evidence of effectiveness or recommended by CDC, that are designed for youth at increased risk, and for which there are curricula, guidelines, materials and nationally available training for facilitators.	3

Persons in Rural Areas or in Ethnic/Language Minority Populations	
Recommended Interventions	Prevention Goal
Partner Counseling and Referral Services (PCRS)	1, 2, 3
HIV Counseling and Testing (HIV CT)	1, 3
HIV Counseling and Testing through Social Networks	1, 3
STD Testing and Partner Services	2, 3
Individual Prevention Counseling in Conjunction with Medical Care	2, 4
Media-based Health Communication/Public Information	3
Other interventions with evidence of effectiveness or recommended by CDC, that are designed for or can be adapted to one or more categories of persons with increased risk, and for which there are curricula, guidelines, materials and nationally available training for facilitators.	3

Table 8. 2007-2009 Priority Populations by Recommended Interventions

	HIV Positive Persons	MSM	IDU	Heterosexual Women at Increased Risk	Heterosexual Men at Increased Risk	Incarcerated Persons	Youth at Increased Risk	Persons in Rural Areas or in Ethnic/Language Minority Populations
PCRS	√	√	√	√	√	√		√
HIV CT		√	√	√	√	√		√
HIV CT through Social Networks		√	√	√	√			√
Single Session Group Presentations With Testing						√		
STD Testing and Partner Services	√	√	√	√	√	√	√	√
Street and Community Outreach			√	√	√		√	
CRCS	√							
Syringe Exchange			√					
Prevention Counseling with Medical Care	√							√
Healthy Relationships	√							
Mpowerment		√						
Making Proud Choices!							√	
Media based HC/PI								√
Other Interventions*	√	√	√	√	√	√	√	√

*Other interventions with evidence of effectiveness or recommended by CDC, that are designed for or can be adapted to one or more categories of persons with increased risk, and for which there are curricula, guidelines, materials and nationally available training for facilitators.

Recommendations for Viral Hepatitis Prevention

Viral hepatitis often affects the populations prioritized for HIV prevention services because of the risk behaviors that transmit these viruses. Like HIV, hepatitis viruses are transmitted through sexual activity and sharing of drug injection equipment or other implements contaminated with blood. Additionally, as with HIV, hepatitis B virus (HBV) can be transmitted perinatally from a woman who is a hepatitis B carrier. Among current and former injection drug users (IDU) living with HIV in the U.S., up to 90% are co-infected with hepatitis C (HCV). It is estimated that between 50 to 80% of IDUs become infected with HVB and HCV within five years of beginning to inject. Men who have sex with men (MSM) are disproportionately affected by both hepatitis A and B. About 15% of all new HBV infections in the U.S. are among MSM. Approximately 15% of persons with chronic HBV infection and 39% of persons with chronic hepatitis C virus infection have a history of incarceration. Vaccines are available to prevent infection with Hepatitis A and B. Medical treatments can help many persons with HCV. CDC recommends the following prevention and testing measures (CDC 2006e):

Injection Drug Users (IDU)

- Hepatitis A and hepatitis B vaccinations
- Hepatitis C virus counseling, testing and referral
- Services for HCV-positive persons
- Substance abuse treatment

Heterosexuals at Increased Risk

- Hepatitis B vaccination

Men Who Have Sex with Men (MSM)

- Hepatitis A and hepatitis B vaccinations

HIV-Positive Persons

- Hepatitis A and hepatitis B vaccinations
- Hepatitis C virus counseling, testing and referral for IDU

Incarcerated Persons

- Hepatitis A and hepatitis B vaccinations
- Hepatitis C virus counseling, testing and referral
- Substance abuse treatment

The Alaska HIV Prevention Planning Group recommends that HIV interventions include information about the risks of viral hepatitis, the benefits of vaccination for hepatitis A and hepatitis B and, for persons with IDU risk factors, referrals for HCV counseling and testing. The Planning Group further recommends that persons with hepatitis C receive HIV counseling and testing, and any necessary service referrals.

Recommendations for Capacity Building

Capacity building refers to a planned process by which individuals, organizations, and communities are assisted to develop skills and abilities to enhance and sustain HIV prevention efforts. Capacity building activities may include, but are not limited to, training, technical assistance, quality assurance guidance, recommendations for materials and intervention models and curricula, assistance in grant writing, and support for organizational and infrastructure development. Capacity building may be provided by the health department, national HIV prevention capacity building providers, or by public or private local, state or national organizations with expertise in the areas of interest.

The HIV Prevention Planning Group recommends:

- For community-based organizations funded for HIV prevention and other HIV prevention providers, and for organizations with ties to priority populations, capacity building activities in the areas of design, implementation, and evaluation of HIV prevention interventions, grant writing, and organizational development.
- For agencies and institutions serving priority populations (such as correctional facilities, substance abuse treatment programs, social service agencies, mental health services, women's shelters, local government agencies, Alaska Native tribal organizations, and programs serving youth), capacity building activities to foster and support the incorporation of HIV prevention into their programs and services.
- For public health and private sector health care providers, training in HIV counseling for use of rapid HIV testing technologies, and promotion of offering HIV testing, when indicated, in the context of clinical care.
- For the Alaska HIV Prevention Planning Group, capacity building activities to support the prevention planning process and the members' interface with their respective communities. To support the HPPG in making recommendations for appropriate interventions, the HPPG requires information on emerging research on effective interventions and on adapting proven interventions to be culturally appropriate for the diverse populations of Alaska.
- For the HIV/STD Program staff, training opportunities to assure that the health department has the capacity to manage and support all components of a comprehensive HIV prevention program.

Recommendations for Needs Assessment

To support the ongoing work of assessing HIV prevention needs and preferences of populations at risk of acquiring or transmitting HIV, the HIV Prevention Planning Group requires the input of the following populations during the period of 2007 to 2009:

- HIV-positive persons;
- Men who have sex with men; and
- Heterosexual women at increased risk.

Additional needs for input from affected communities and populations may emerge within the time period covered by the Plan.

Recommendations for Evaluation

The HPPG supports the use of HIV Prevention funds to evaluate the community planning process and the HIV prevention activities carried out by the HIV/STD Program and its grantees and contractors. Continuation is recommended for the activities below.

The HPPG participates in an annual self-evaluation to assess its achievement of the core objectives of community planning. The HPPG annually examines the state health department's application to CDC to assess its correspondence with the Comprehensive Plan. Annually the health department presents to the HPPG data on the allocation of HIV prevention resources so that the HPPG can assess the correspondence between this resource allocation and the Comprehensive Plan.

The HIV/STD Program requires process evaluation data on all funded interventions that are carried out by grantees, contractors, or Program staff. Process data provide information on the reach and retention of the intervention and the demographic characteristics of participants. The HIV/STD Program uses these data to monitor the implementation of funded activities and presents summary data to the HPPG in support of the planning process. Grantee organizations use these data to monitor their programs' progress toward their objectives and to inform their program planning.

Other Health Department Activities Carried Out Under the CDC Cooperative Agreement

The HPPG endorses the use of HIV prevention funds under the CDC cooperative agreement to assure that the Alaska HIV/STD Programs retains the staff and infrastructure to implement all components of a comprehensive HIV prevention program. In addition to the health department's responsibilities noted in previous sections of the Plan with respect to community planning, HIV prevention activities, capacity building and evaluation, the HIV/STD Program must have the ability to: prepare grant applications and reports; manage grants to CBOs and other agencies; implement quality assurance systems; respond to the surveillance data needs of the HPPG, prevention programs, and providers; oversee a material review panel for ongoing review of educational materials; collaborate and coordinate with other state and community agencies, health department programs, and Alaska Native tribal organizations that serve priority populations as defined in the Plan; and provide guidance on policy issues related to HIV/AIDS for the State of Alaska.

Chapter 7

Overview of the Community Planning Process



2007-2009 Alaska HIV Prevention Plan

Chapter Seven: Overview of the Community Planning Process

HIV Prevention Community Planning

Since January 1994, state, territorial, and local health departments receiving HIV prevention funds through the CDC have conducted community planning activities to develop comprehensive HIV prevention plans. In Alaska, a statewide Alaska HIV Prevention Planning Group (HPPG) was organized in 1994 to guide the planning process. It is the joint responsibility of the HPPG members and the health department to implement HIV prevention community planning. This collaborative planning process aims to improve the effectiveness of HIV prevention programs through the participation of individuals who are affected by HIV/AIDS and who are knowledgeable about HIV prevention and Alaska communities. Persons who reflect the perspective of the populations most affected by HIV, as well as epidemiologists, social scientists, providers, and State HIV/STD Program staff, work together to develop a statewide prevention plan that best represents the needs of populations at risk for, or infected with, HIV/AIDS.

Goals of HIV Prevention Community Planning

The CDC has defined three major goals to provide an overall direction HIV prevention community planning:

Goal One — Community planning supports broad-based community participation in HIV prevention planning.

Goal Two — Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

Goal Three — Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

Guiding Principles for HIV Prevention Community Planning

To ensure that the HIV prevention community planning process is carried out in a participatory manner, the CDC has specified the following Guiding Principles of HIV Prevention Community Planning:

1. The health department and community planning group must work collaboratively to develop a comprehensive HIV prevention plan for the jurisdiction.
2. The community planning process must reflect an open, candid, and participatory process, in which differences in cultural and ethnic background, perspective, and experience are essential and valued.

3. The community planning process must involve representatives of populations at greatest risk for HIV infection and people living with HIV/AIDS (PLWHA).
4. The fundamental tenets of community planning are parity, inclusion, and representation.

Parity is the condition whereby all members participate equally in the planning process and have equal voice in voting and other decision-making activities.

Inclusion is the assurance that the views, perspectives, and needs of all affected communities are included and involved in a meaningful manner in the community planning process.

Representation means that members reflect the perspective of a specific community and that they understand that community's values, norms, and behaviors. Representatives must also be able to participate as group members in objectively weighing the overall priority prevention needs of the State.

5. An inclusive community planning process includes representatives of varying races and ethnicities, genders, sexual orientations, ages, and other characteristics such as varying educational backgrounds, professions, and expertise.
6. The community planning process must actively encourage and seek out community participation.
7. Nominations for membership should be solicited through an open process and candidates' selection should be based on criteria established by the health department and the community planning group.
8. An evidence-based process for setting priorities among target populations should be based on the epidemiologic profile and the community services assessment.
9. Priority setting for target populations must address populations for which HIV prevention will have the greatest impact.
10. The set of prevention interventions/activities for prioritized target populations should have the potential to prevent the greatest number of new infections.

Current Alaska HIV Prevention Group Members

Members of the Alaska HPPG are volunteers, selected for their knowledge and personal experience related to HIV and risk behaviors, as well as their technical expertise in program planning, evaluation, epidemiology, behavioral science, and other fields related to prevention. Members are diverse in race/ethnicity, serostatus, socioeconomic level, sexual orientation,

education, and areas of expertise. The HPPG's Membership Workgroup reviews HPPG composition and membership needs, and presents criteria to the HPPG for new members' characteristics to address those needs. Recruitment activities identify the criteria being sought in new members and HPPG member nominations are solicited from consumers and HIV prevention providers throughout the state representing both governmental and non-governmental agencies. The State Epidemiologist, in the Division of Public Health, Department of Health and Social Services, appoints members.

A charter that describes the purpose, duties, liaisons, membership, records, and governance of meetings, subcommittees, and working teams guides the HPPG. Meetings are generally held quarterly and additional meetings and/or teleconferences for the full HPPG may be scheduled if deemed necessary by the co-chairs. Three HPPG members, two of whom are community members and one of whom represents the Alaska Department of Health and Social Services, share the Chair of the Alaska HPPG. Facilitation of meetings is rotated among the three co-chairs. At the time of publication of the *2007-2009 Alaska HIV Prevention Plan*, the HPPG was composed of the following members:

Scott Bailey, Anchorage
Hugh Brown, III, Community Co-chair, Anchorage
Victor Carlson, Anchorage
Sarah Carter, Anchorage
Wendy Craytor, Health Department Co-chair, Anchorage
Gloria Eldridge, Anchorage
Pearlene Hernandez, Anchorage
Michael Jones, Community Co-chair, Anchorage
Sigvold Juliussen, Anchorage
Elizabeth Lee, Bethel
Cheryl Loudermilk, Anchorage
Brenda Reichenberg, Fairbanks
Golga Sakar, Anchorage
Simon Tony-Abraham, Toksook Bay
Barbara Wilson, Fairbanks
Margaret Wilson, Fairbanks

Efforts are made to organize a diverse planning group that is guided by the fundamental tenets of HIV prevention community planning: parity, inclusion and representation.

Community Input Process

In addition to the HPPG's membership, the prevention planning process includes multiple activities to seek input from populations at increased risk, service providers to these populations, experts in related fields, and interested others. HPPG meetings are open to the public and each full meeting includes a public comment period. Meetings are posted on the State's website and advertised through listserve announcements. There are liaisons to the HPPG from three state

agencies with important roles in HIV prevention in Alaska and are regularly invited to attend meetings. Liaisons to the HPPG from 2004 to 2006 were:

Terri Campbell and Todd Brocious, Department of Education and Early Development
Viki Wells, Division of Behavioral Health, Department of Health and Social Services
Sara Williams, Department of Corrections

Other specific individuals and agency representatives are specially invited to participate in HPPG meetings where their expertise or interest is particularly relevant. Prevention provider teleconference participants, which include over 50 providers statewide, and other individuals or agencies known to be interested and involved in HIV prevention are regularly advised of the HPPG's meeting dates.

The Alaska HPPG and the Alaska Ryan White CARE Consortia and lead agencies share information and mutual participation in their respective activities through several mechanisms. Since the Alaska HIV/STD Program supports both groups, communication about prevention and care activities is easily facilitated by HIV/STD Program staff. Generally there is some overlapping membership between the HPPG and one or more HIV CARE Consortia. Data from Ryan White CARE Act activities are shared with the HPPG and included in the needs assessment process. Reciprocally, the comprehensive Plan is shared with the CARE Consortium. Prevention and care providers and HPPG members receive epidemiologic data in Section of Epidemiology *Reports and Recommendations* and *Epidemiology Bulletins*. Since 2001, there has been an increase in the interaction between the HPPG and the Ryan White CARE services with the implementation of more prevention activities for HIV-positive persons.

Beginning in 2000, HPPG information was made available on the Internet through the Section of Epidemiology web site at <http://www.epi.hss.state.ak.us/hivstd/hppg>. Approved meeting minutes, upcoming meeting dates and agendas, a list of current HPPG members and their areas of residence, and applications for HPPG membership are posted on the website. The current *Alaska HIV Prevention Plan* is posted on the website and public comment is welcome.

Appendix A

Epidemiologic Profile



2007-2009 Alaska HIV Prevention Plan

Appendix A: Epidemiologic Profile

OVERVIEW

Through December 31, 2005, 1,048 cases of HIV/AIDS were reported in Alaska, 318 with HIV infection without AIDS and 730 with AIDS. Of the 1,048 cases, 846 cases (81%) were in males and 202 cases (19%) were in females.

On average, 40 HIV/AIDS cases were newly diagnosed per year from 2001-2005, a decline from the average of 52 cases per year in the period from 1996-2000. Beginning in 1996, HIV-related deaths declined significantly in Alaska and in the U.S., primarily due to advances in medical care and treatment. The decline in deaths and a relatively constant rate of new infections resulted in a steady increase in the number of persons in the population living with HIV. Needs for medical care, supportive services, and ongoing prevention services will continue to grow as persons with HIV live longer, healthier lives.

Since the earliest identified cases in Alaska, as occurred nationally, the number and proportion of HIV/AIDS cases in males exceeded those in females. Over time, the proportion of cases in males declined and the proportion of cases in females increased. In the most recent five-year period (2001-2005), an average of 29 HIV/AIDS cases (73% of total cases) per year in Alaska were in males compared to an average of 11 HIV/AIDS cases (27% of total cases) per year in females.

Seventy-one percent of all HIV cases were first diagnosed in persons between the ages of 25 and 44 years. The largest numbers of cases (214; 20% of the total) were in persons aged 30-34 years at first HIV diagnosis. A greater proportion of female than male cases occurred in persons in a younger age group at the time of first HIV diagnosis (19% of females were aged 15-24 years, and 11% of males).

Fortunately, unlike some other areas of the U.S., HIV infection was uncommon in adolescents in Alaska, although behaviors placing individuals at increased risk of HIV exposure were relatively common in this population. Through December 31, 2005, a cumulative total of 135 cases of HIV/AIDS were reported in Alaska in persons aged 13-24 years at first HIV diagnosis (13% of the 1,048 cumulative HIV/AIDS cases). Of the 135 cases, 97 (72%) cases were in males and 38 (28%) cases were in females. The proportion of HIV/AIDS cases first diagnosed from 2001-2005 in persons 13-24 years of age (12%) was slightly less than the proportion first diagnosed in persons in this age group from 1982-2000 (13%).

Male-to-male sexual contact (MSM) represented, by far, the largest single risk for infection both for the total population of persons reported with HIV infection in Alaska through December 31, 2005 (48% of all cumulative cases) and for the population of males only, where MSM accounted for 59% of cases. Injection drug use (IDU) as a single transmission category accounted for 14% of cumulative cases (12% of cases in males and 22% of cases in females). Cases with both MSM and IDU risks accounted for an additional 7% of total cases and 8% of cases in males. Heterosexual contact to a person at increased risk for HIV (for example, a known HIV-positive, an IDU, or, for females, a bisexual male) accounted for 15% of total cumulative cases (6% of cases in males and 51% of cases in females). The proportions of total cumulative cases related to

perinatal transmission, transfusion or transplantation, or receipt of blood products for hemophilia remained low at 1%, each.

HIV infection affected individuals in all racial and ethnic groups. In Alaska, as in the U.S., the proportion of HIV/AIDS cases in Whites decreased in recent years. As a result, the proportion of HIV/AIDS cases in racial/ethnic minority persons increased. Of the 1,048 cases reported through 12/31/05, 606 (58%) were in Whites, 238 (23%) in Alaska Natives/American Indians, 98 (9%) in Blacks, 73 (7%) in Hispanics, 20 (2%) in Asian/Pacific Islanders, and 13 (1%) were of unknown race/ethnicity. Compared to their proportions of the state's population, Alaska Natives/American Indians, Blacks, and Hispanics were over-represented among HIV/AIDS cases.

HIV cases were reported from all regions of the state through December 31, 2005. At the time of their first HIV diagnosis in Alaska, 672 cases (64%) had a reported residence of Anchorage/Mat Su, the most populous region of the state (53% of the state population resided in the Anchorage/Mat Su region in 2005). A total of 747 cases (71%) resided in the urban areas of Anchorage, Fairbanks or Juneau (60% of the state's 2005 population) at the time of their first HIV/AIDS diagnosis in Alaska.

From 2001-2005, 36% of persons with Alaska residence at first HIV diagnosis developed AIDS within 12 months of their initial HIV diagnosis. This likely indicates diagnosis late in the course of their HIV disease. Late diagnosis limits an individual's potential benefit from medical care and additionally indicates a lengthy period during which an infected person may have unknowingly transmitted HIV to others.

Although a number of individuals with HIV are presumed to be unaware of their infection, HIV screening of the general population in Alaska has not been particularly effective in identifying previously undiagnosed HIV infection. Different models of targeted outreach associated with testing, some using rapid HIV tests, are being explored to identify ways to best reach those at risk. Partner notification activities, working with persons diagnosed with HIV to alert their sexual and needle-sharing partners of their exposure, remain the most effective means of reaching persons at highest risk prior to symptomatic disease. From 2003-2005, partner notification activities identified 37% of all cases of HIV newly diagnosed in Alaska.

Antiretroviral therapy is effective in reducing the potential for HIV transmission during pregnancy, delivery, and postpartum, and has helped reduce perinatal infection rates in Alaska and nationwide. The majority of pregnant women in Alaska received HIV screening as part of their prenatal care through 2003.

The occurrence of sexually transmitted diseases (STD) indicates sexual risk behavior, and individuals with STD are at increased risk of acquiring or transmitting HIV through sexual contact, if exposed. Chlamydia and gonorrhea infections occurred in many sexually active young adults in Alaska in 2005. The population of individuals reported with HIV did not overlap to a great extent with populations reported with gonorrhea or chlamydia. In contrast, HIV infection was considerably more prevalent in persons identified with infectious syphilis from 2004-2005.

The following sections present detailed data on HIV infection in Alaska, expanding on the summary information provided in Chapter 2.

Considerations Regarding Data and Methods

The first case of AIDS was reported in Alaska in 1982. Even though a test for HIV, the causative agent, had not yet been developed at that time, the case was reportable to the Division of Public Health as an unusual incidence of infectious disease, and the provider sought consultation with the State's epidemiologists. AIDS became a condition specifically reportable to the Alaska Division of Public Health in 1985. A laboratory test for HIV antibody became commercially available in the U.S. in 1985 as well. In February 1999, HIV infection (without AIDS) was made a reportable condition in Alaska. Under current Alaska Administrative Code (7 AAC 27.005 and 7 AAC 27.007), medical providers are required to report suspected and diagnosed cases of HIV infection and AIDS, and laboratories are required to report evidence of infection with HIV, to the Division of Public Health.

For surveillance purposes, each HIV or AIDS case is counted only once, rather than once when reported with HIV and again when reported with AIDS. Most of the data presented in this appendix and in the Epidemiologic Profile Summary (see Chapter 2) represent all cases of HIV or AIDS ever reported in Alaska, regardless of the state of residence at first diagnosis. This approach has been selected because these data are likely to represent individuals with HIV who potentially need prevention and care services. Only when a table or figure title specifies that the data presented are specifically for "Alaska cases" do the cases represent individuals first diagnosed with HIV infection (with or without AIDS) while they were residents of the state of Alaska, regardless of where that diagnosis occurred.

Reported date of first HIV diagnosis is used as a substitute for HIV infection incidence, realizing that individual cases are diagnosed at different times, ranging from months to years after time of infection. Similarly, clinical detection of AIDS-defining conditions (the AIDS diagnosis) occurs at different points in the disease continuum for different individuals. Date of first known AIDS diagnosis is used as a surrogate measure for AIDS onset. Unless otherwise noted, data are presented by year of first known HIV diagnosis (to estimate onset of HIV infection) rather than by the year they were first reported to the Alaska Division of Public Health.

After HIV reporting was introduced in February 1999, cases were reported in persons who had been diagnosed with HIV many years earlier as well as in persons who were more recently infected or recently diagnosed for the first time. Reports on HIV/AIDS cases diagnosed prior to 1999 were more likely than reports on more recently diagnosed cases to have some data elements incomplete. Since 1999, it has been possible to gather more complete data on some, but not all, of these earlier cases (some may have died, moved out of state, or have been otherwise lost to follow-up).

People with HIV and AIDS undergo the same kinds of life events as people without HIV infection -- they move into or out of Alaska, they may or may not interact with medical providers while they live here, and they may die of HIV or unrelated causes in Alaska or elsewhere.

Multiple types of surveillance activities are necessary to provide a complete picture of HIV infection in Alaska. Reported disease data are considered to be indicators of the situation at any point in time, rather than definitive measures, and the data are used in conjunction with information about local conditions to guide public health interventions. Case numbers presented in this document may differ from data presented in other Section of Epidemiology reports because HIV/AIDS case data are updated on an ongoing basis as new case-related information becomes available.

The following sections present available data in different ways to depict cumulative and current aspects of the HIV epidemic in Alaska. In many sections of this report, data are presented as proportions. It is important to recognize that proportions represented by each of the constituent elements must add up to the whole (100%, although rounding of individual proportions to the nearest whole number may result in their totaling slightly more or less than 100%). When one proportion decreases, one or more of the other proportions must increase. A proportionate increase does not necessarily mean that rates have changed. It is important to consider the actual number of cases or events involved and rates, along with any changes in proportions, before drawing conclusions. Alaska case numbers are relatively small and fluctuations over time may make proportions and rates relatively unstable. All data must be interpreted in the context of cumulative scientific knowledge about HIV/AIDS.

OVERALL HIV/AIDS CASE RATES IN ALASKA AND THE UNITED STATES

Alaska AIDS and HIV case rates for the most recent five years, as well as the data used to calculate them, are presented below in Table 1. In Table 1 and Figure 1, Alaska HIV and AIDS cases are defined as those cases that were in Alaska residents at their first known date of HIV diagnosis, even if the diagnosis took place at a facility out of state. Case rates are expressed per 100,000 population. Because Alaska case numbers are small and may fluctuate from year to year, a five-year (2001-2005) mean annual rate is also presented to offer a more stable estimate of the incidence rates in Alaska.

The mean annual rate of Alaska AIDS cases (those first diagnosed with AIDS while Alaska residents) from 2001-2005, or the mean annual AIDS incidence rate, was 1.9 cases per 100,000 population. In comparison, the estimated 2004 AIDS incidence rate in the 50 U.S. states and the District of Columbia was 14.1 AIDS cases per 100,000 population (most recent published CDC data in *HIV/AIDS Surveillance Report, 2004*, Vol. 16, Table 5a).

The mean annual Alaska HIV incidence rate (cases of HIV with and without AIDS that were Alaska residents at first HIV diagnosis) for the period from 2001-2005 was 5.1 cases per 100,000 population (Table 1). In comparison, the 2004 HIV/AIDS incidence rate for the 33 states, plus Guam and the Virgin Islands, with confidential HIV reporting since 2000 was 20.7 cases per 100,000 population (Figure 1; U.S. rates were calculated from CDC data published in the *HIV/AIDS Surveillance Report, 2004*, Vol. 16, Table 5b).

Table 1. Alaska* AIDS and HIV (with and without AIDS) Incidence Rates, 2001-2005

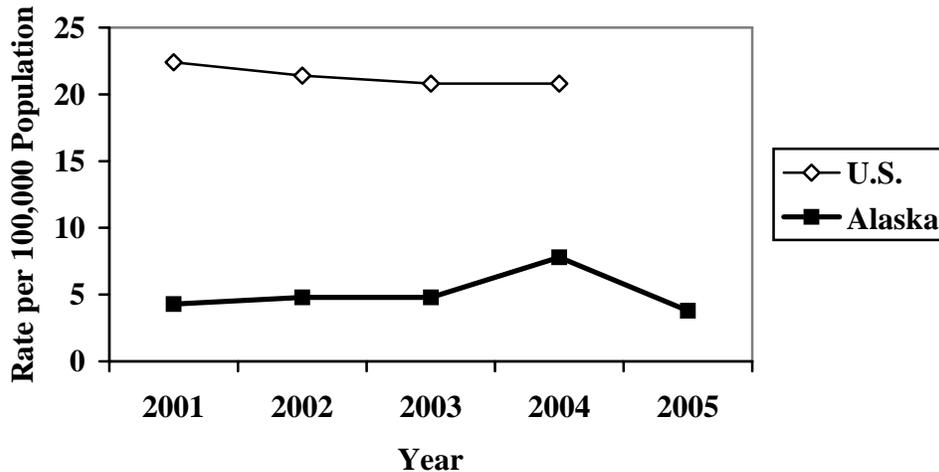
Year	Alaska AIDS Cases (Number)	Alaska AIDS Incidence Rate per 100,000 Population	Alaska HIV** Cases (Number)	Alaska HIV** Incidence Rate per 100,000 Population	Alaska Population***
2001	12	1.9	27	4.3	632,249
2002	12	1.9	31	4.8	640,699
2003	14	2.2	31	4.8	648,510
2004	18	2.7	51	7.8	657,755
2005	4	0.6	25	3.8	663,661
Total	60	1.9	165	5.1	3,242,874
Mean	12.0	1.9	33.0	5.1	648,575

*Alaska cases in Table 1 include only those with first HIV diagnosis while an Alaska resident

**HIV cases include those with and without AIDS

***Population data are from the Alaska Department of Labor and Workforce Development, Alaska State Estimates

Figure 1. HIV Incidence (with and without AIDS) 2001-2005, Alaska* and U.S.



* Alaska cases in Figure 1 include only those with first HIV diagnosis while an Alaska resident

DATA ON ALL HIV/AIDS CASES REPORTED IN ALASKA

The following section presents data on all confirmed cases of HIV, with and without AIDS, ever reported in Alaska. These data reflect the most current information available at the time of publication and, as a result, may differ from data in prior Section of Epidemiology publications.

Through December 31, 2005, a cumulative total of 1,048 cases of HIV infection, with and without AIDS, were reported to the Alaska Division of Public Health (Table 2).

Table 2. Cumulative HIV and AIDS Cases Reported to the Alaska Division of Public Health through December 31, 2005 N=1,048

	Total HIV & AIDS Cases Reported In Alaska	HIV & AIDS Cases Not Known to Have Died	HIV & AIDS Cases Known to Have Died
HIV Cases with AIDS	730	411	319
HIV Cases without AIDS	318	293	25
Total Reported HIV/AIDS Cases	1,048	704	344

Cumulative HIV cases (with and without AIDS) and known deaths due to any cause are shown in Figure 2 and Table 3. In these two graphs/ tables, a death is reflected in the year the case was first diagnosed (rather than the year in which the death occurred) to better reflect case mortality. These data illustrate the reduction in HIV mortality in recent years, primarily due to improved medical treatment, and also reflect earlier detection of HIV infection in some individuals.

Figure 2. Cumulative HIV Cases and Known Deaths by Year of First Known HIV Diagnosis through December 31, 2005, Alaska N=1,048 (1 case with unknown date of diagnosis is not included below)

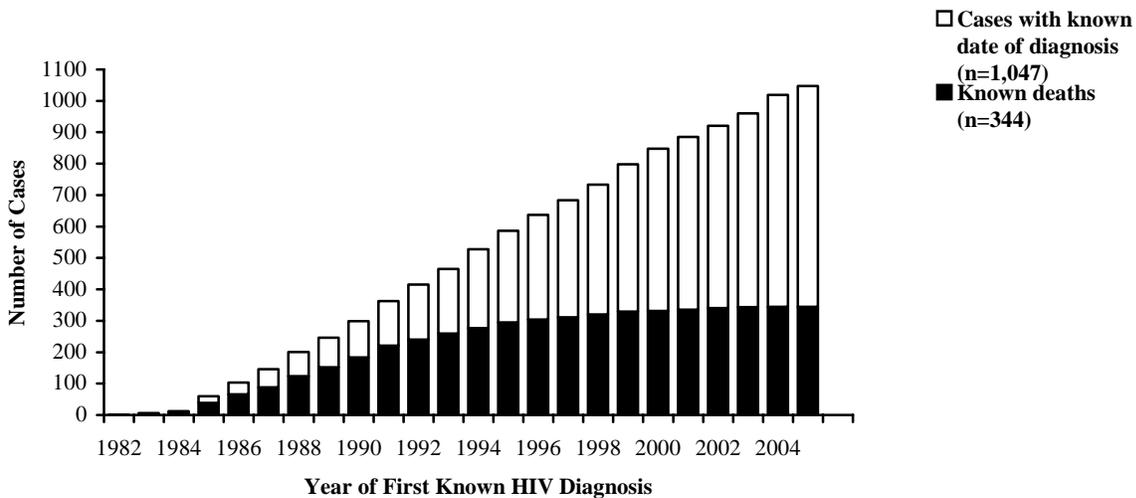


Table 3. HIV Cases and Known Deaths by Year of First Known HIV Diagnosis through December 31, 2005, Alaska N=1,048

Year	Cases by Year of First Known HIV Diagnosis	Known Deaths Among Persons Diagnosed with HIV in that Year
1982	1	1
1983	5	3
1984	6	4
1985	48	30
1986	43	28
1987	43	22
1988	55	36
1989	45	28
1990	53	31
1991	64	38
1992	52	19
1993	50	19
1994	63	18
1995	58	18
1996	51	9
1997	47	7
1998	49	9
1999	65	9
2000	50	2
2001	37	4
2002	36	5
2003	39	3
2004	59	1
2005	28	0
Unknown	1	0
Total	1,048	344

The number of individuals in the population who are living with HIV continues to grow, as new individuals become infected and previously infected individuals live longer. As the number of persons living with HIV continues to increase, needs for medical care, treatment, and supportive services will also grow. Additional data on persons who are presumed living with HIV are presented later in this appendix.

Gender

Female - Of 1,048 cumulative HIV cases reported in Alaska through 2005, 202 cases (19%) were in females. The numbers and proportion of cases in females were smaller than in males, consistent with national trends. The average annual number of HIV cases among females in Alaska increased from 1982 through 2000 (from an average of 1 case per year to an average of 14 cases per year), then decreased for the period from 2001-2005 (to an average of 11 cases per year). The proportion of total cases occurring in females increased steadily over time, from 8% to 27%. In recent periods this proportionate increase was due primarily to a decline in the number and proportion of cases in males (Table 4).

Male - Of 1,048 cumulative Alaska HIV cases, 846 cases (81%) were in males. The average annual number of HIV/AIDS cases newly diagnosed in males decreased in time periods after 1990 (Table 4).

Table 4. Average Number of HIV/AIDS Cases Newly Diagnosed per Year by Gender, Time Periods from 1982-2005, Alaska N=1,048 (one case with unknown year of diagnosis is not included in the table)

Time Period	Average Number of HIV/AIDS Cases Newly Diagnosed Per Year				Average Total Number of HIV/AIDS Cases Per Year in Time Period, Males & Females**
	Males		Females		
	Average Number of Male Cases Per Year	Proportion of Male Cases in Total HIV/AIDS Cases During Time Period	Average Number of Female Cases Per Year	Proportion of Female Cases in Total HIV/AIDS Cases During Time Period	
1982-1985*	14	92%	1	8%	15
1986-1990	43	90%	5	10%	48
1991-1995	48	83%	10	17%	57
1996-2000	38	73%	14	27%	52
2001-2005	29	73%	11	27%	40

*First AIDS case diagnosed in Alaska in 1982

**Due to rounding, the sum of the average number of cases for males and the average for females may not always equal the average total number of male and female cases (e.g., in 1991-1995, the average total number of cases per year is actually 57 rather than 48+10=58)

Although the average annual number of new cases from 2001-2005 is the smallest since 1982-1985, it shows ongoing incidence of new HIV infection.

Age

Of HIV cases reported in Alaska, 741 (71%) were first diagnosed in individuals aged 25 to 44 years of age. Unlike some other areas of the U.S., relatively few HIV cases were reported among very young people in Alaska: 13 (1%) of 1,048 cases were aged 0-14, 23 (2%) were aged 15 –19, and 111 (11%) were aged 20-24 years at time of first HIV diagnosis (Figure 3, Table 5). Characteristics of persons diagnosed with HIV while adolescents/young adults (aged 13-24 years) are discussed later in this appendix.

Figure 3. Cumulative HIV Cases through December 31, 2005 (with and without AIDS) by Age at First Known HIV Diagnosis, Alaska N=1,048 (1 case with unknown age not shown below)

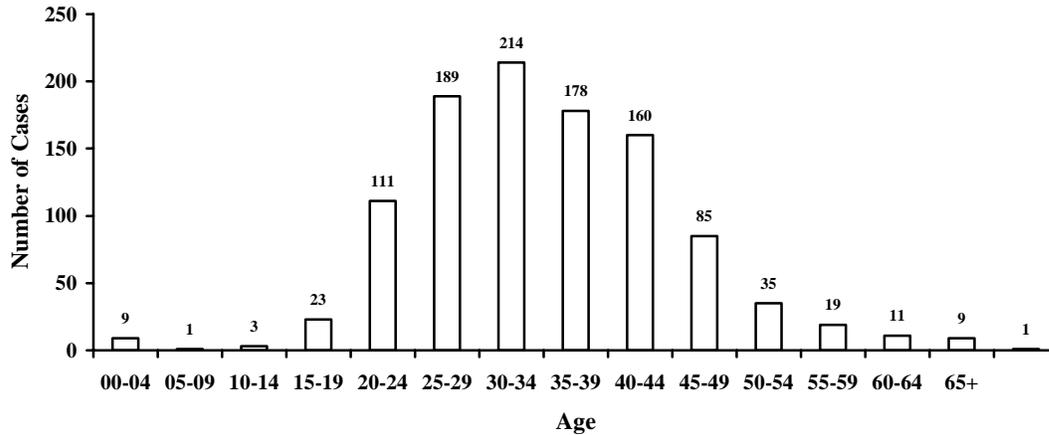


Table 5. Cumulative HIV Cases (with and without AIDS) by Gender and Age at First Known HIV Diagnosis through December 31, 2005, Alaska N=1,048

Age Group	Males		Females		Total	
	Number	Column %	Number	Column %	Number	Column %
00-04	5	1%	4	2%	9	1%
05-09	1	<1%	0	0%	1	<1%
10-14	3	<1%	0	0%	3	<1%
15-19	12	1%	11	5%	23	2%
20-24	84	10%	27	13%	111	11%
25-29	150	18%	39	19%	189	18%
30-34	177	21%	37	18%	214	20%
35-39	151	18%	27	13%	178	17%
40-44	136	16%	24	12%	160	15%
45-49	67	8%	18	9%	85	8%
50-54	27	3%	8	4%	35	3%
55-59	16	2%	3	1%	19	2%
60-64	10	1%	1	<1%	11	1%
65+	6	1%	3	1%	9	1%
Unknown	1	<1%	0	0%	1	<1%
Total	846	100%	202	100%	1,048	100%

Among total cumulative HIV cases, a greater proportion of female (19%) than male (11%) cases occurred in persons aged 15-24 years at the time of first HIV diagnosis. The proportion of cases aged 35-44 years at first HIV diagnosis was greater for males (34%) than females (25%).

Transmission Category

In order to have consistent national data that are comparable across areas, HIV/AIDS cases are categorized according to specific national definitions in a hierarchy the CDC has established to identify the risk factor most likely to have been responsible for transmission. Individuals who have more than one reported risk factor are counted in only one exposure category (the category listed highest in the CDC hierarchy), except that men who report both sexual contact with other men and injection drug use make up a separate CDC transmission category. Several CDC transmission categories are defined in ways that may not be intuitively obvious from the titles:

Male-to-male sexual contact cases include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact).

Heterosexual contact cases include only those cases reporting heterosexual contact with a person with, or at increased risk for, HIV infection (for example, an injection drug user). Cases where contact was not with an infected person or a person known to be at increased risk are classified as *No risk reported or identified*.

No risk reported or identified cases are in individuals with no reported exposure to HIV through any of the routes listed in CDC's hierarchy of transmission categories. This case classification additionally includes:

- cases currently under investigation by the health department;
- cases with incomplete exposure history because the person died, declined to be interviewed, or was lost to follow up; and
- cases that were interviewed or for which other follow-up information was available and no mode of exposure was identified.

Newly reported cases of HIV infection are more likely to have incomplete transmission risk information than cases reported earlier and for which risk information may have been added over time.

Figure 4. Cumulative HIV Cases (with and without AIDS) by Transmission Category through December 31, 2005, Alaska (N=1,048)

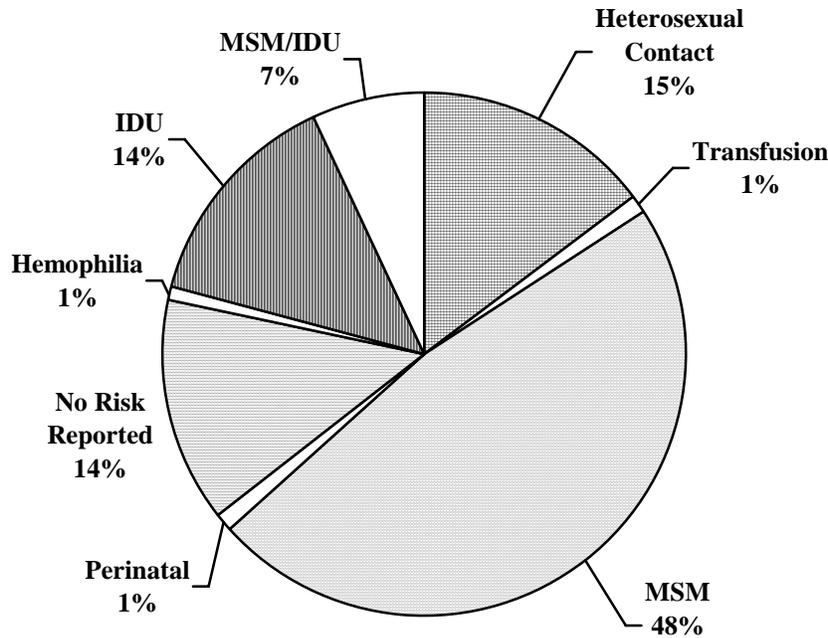


Table 6. Cumulative HIV Cases (with and without AIDS), Transmission Category by Gender through December 31, 2005, Alaska (N=1,048)

Transmission Category	Males		Females		Total	
	Number	Column %	Number	Column %	Number	Column %
Male-to-Male Sexual Contact (MSM)	501	59%	NA	NA	501	48%
Injection Drug Use (IDU)	100	12%	45	22%	145	14%
MSM and IDU	70	8%	NA	NA	70	7%
Heterosexual Contact to At-Risk Person	51	6%	104	51%	155	15%
Transfusion/Transplant	10	1%	3	1%	13	1%
Hemophilia	10	1%	0	0%	10	1%
Perinatal Transmission	3	<1%	4	2%	7	1%
No Risk Reported/Identified	101	12%	46	23%	147	14%
Total	846	100%	202	100%	1,048	100%

Male-to-male sexual contact (MSM) represented, by far, the largest single risk for infection both for the total population of persons reported with HIV infection in Alaska (48% of all cumulative cases) and for the population of males only, where MSM accounted for 59% of cases. Injection

drug use (IDU) as a single transmission category accounted for 14% of cumulative cases (12% of cases in males and 22% of cases in females). Cases with both MSM and IDU risks accounted for an additional 7% of total cases and 8% of cases in males. Heterosexual contact to a person at increased risk for HIV (for example, a known HIV-positive, an IDU, or, for females, a bisexual male) accounted for 15% of total cumulative cases (6% of cases in males and 51% of cases in females). The proportions of total cumulative cases related to perinatal transmission, transfusion or transplantation, or receipt of blood products for hemophilia remained low at 1%, each.

Of total cumulative cases, 147 cases (14% of all cases; 12% of males and 23% of females) were classified as having no transmission risk reported or identified (this category is defined more fully at the beginning of this section). This proportion, while significant, is considerably lower than that shown in the CDC 2004 *HIV/AIDS Surveillance Report* for all of the 42 U.S. areas with confidential name-based HIV infection reporting (28% of all adult/adolescent cases; 24% of males and 36% of females). Some of the cases reported in Alaska with no risk identified, particularly those reported more recently, will be reclassified to other transmission categories over time as additional case-related information becomes available.

Race/Ethnicity

HIV affects individuals in all racial and ethnic groups in Alaska. Although individuals are not at risk of HIV infection due to their race/ethnicity, it can be an indicator of economic and social factors that may influence risk of exposure to HIV.

Several studies in other areas of the country have documented misidentification of American Indians and Alaska Natives (AI/AN) in disease surveillance databases and on death certificates as evidence that HIV/AIDS cases among AI/AN were underreported nationally. In contrast, misidentification of Alaska Native/American Indian cases is not a significant problem in Alaska. A 1992 study by the Section of Epidemiology found no underreporting among AI/AN cases of AIDS in Alaska at that time. In 2002, the Section of Epidemiology again undertook an assessment of the accuracy of the race/ethnicity data recorded for HIV/AIDS cases in collaboration with the Centers for Disease Control and Prevention and the Indian Health Service (IHS).

The IHS National Patient Information and Reporting System served as the best available source for AI/AN status in the 2002 study. Of the 847 HIV/AIDS cases reported in Alaska through June 2002, 182 were AI/AN; six (3.3% of the total) were found to have been inappropriately coded as White or Hispanic. These cases included four American Indian and two Alaska Native cases. Coding was corrected on these cases in the Alaska data (and these changes are reflected throughout this report). An additional 15 cases classified in the Alaska database as AI/AN were not found in the IHS database. These cases were retained as AI/AN cases in Alaska's database on the basis of other evidence.

Data on all cumulative HIV cases by race/ethnicity are presented in Figure 5, and by race/ethnicity and gender in Table 7, below. Please note that the HIV *case* data classify

individuals of Hispanic ethnicity as a separate race/ethnicity category while the Alaska *population* data include individuals of Hispanic ethnicity within the other (race) categories.

Figure 5. Cumulative HIV Cases (with and without AIDS) by Race/Ethnicity through December 31, 2005, Alaska N=1,048

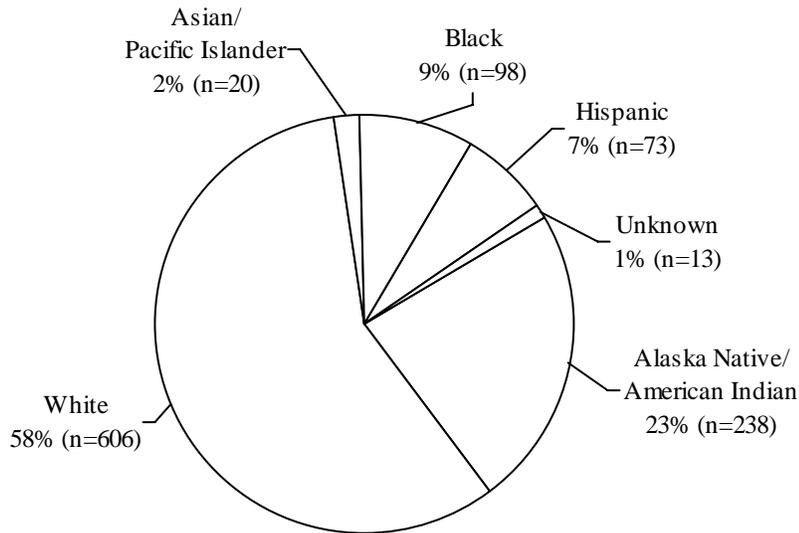


Figure 6. Alaska Population by Race, July 1, 2005 (Department of Labor and Workforce Development's Alaska State Race Bridged Smooth Series; persons of Hispanic ethnicity constitute 4% of population and are included within race categories)

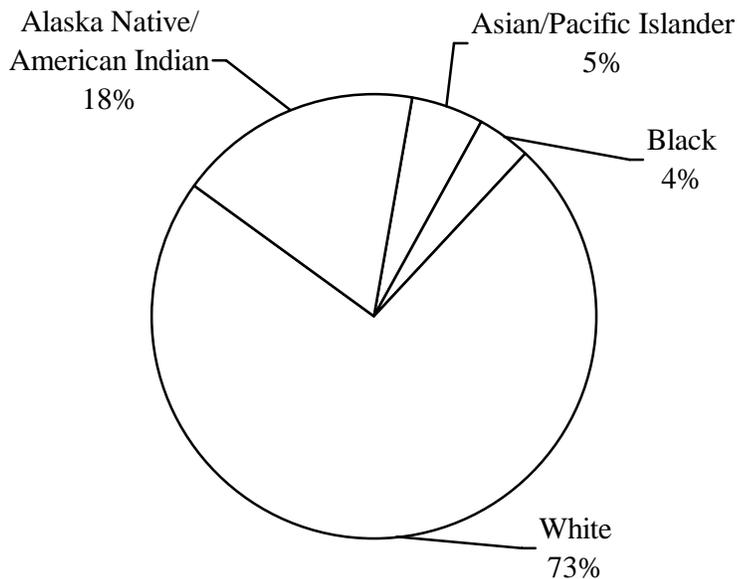


Table 7. Cumulative HIV Cases (with and without AIDS) Diagnosed through December 31, 2005 by Gender and Race/Ethnicity, Alaska (N=1,048)

Race/Ethnicity	Males		Females		Total	
	Number	Column %	Number	Column %	Number	Column %
White	518	61%	88	44%	606	58%
Alaska Native/ American Indian	170	20%	68	34%	238	23%
Black	71	8%	27	13%	98	9%
Asian/Pacific Islander	15	2%	5	2%	20	2%
Hispanic Ethnicity	62	7%	11	5%	73	7%
Unknown Race/Ethnicity	10	1%	3	1%	13	1%
Total	846	100%	202	100%	1,048	100%

For adult/adolescent males and females, HIV infection affected Whites and Asian/Pacific Islanders in proportions less than their representation in the Alaska population, while HIV affected Alaska Native/American Indians, Blacks, and Hispanics in proportions greater than their representation in the overall Alaska population. A disproportionate representation of Blacks and Hispanics in persons with HIV is also seen in the U.S. as a whole.

Population data on Tables 8 to 10 are estimates by the Alaska Department of Labor and Workforce Development of the 2005 Alaska population reapportioned into single race categories. Persons of Hispanic ethnicity are included within each of the race categories in these population estimates. The 2005 Alaska Hispanic population is also estimated separately.

Table 8. Cumulative HIV Cases (with and without AIDS) Diagnosed through December 31, 2005 by Race/Ethnicity and 2005 Alaska Population

Race/Ethnicity	HIV/AIDS Cases		Alaska 2005 Population Data Reapportioned into Four Races*	
	Number	% Total	Number	% Total
White	606	58%	484,332	73%
Alaska Native/American Indian	238	23%	117,743	18%
Black	98	9%	26,311	4%
Asian/Pacific Islander	20	2%	35,275	5%
Hispanic Ethnicity	73	7%	[26,413]**	[4%]**
Unknown Race/Ethnicity	13	1%	---	---
Total	1,048	100%	663,661	100%

* Population data are from the Alaska Department of Labor and Workforce Development's Alaska State Race Bridged Smooth Series estimates for July 1, 2005

**Persons of Hispanic/Latino ethnicity are included within the race categories in the population data (White, Alaska Native/American Indian, Black, Asian/Pacific Islander), as well as shown separately

Data on HIV/AIDS by race and ethnicity, as well as Alaska population estimates by race and ethnicity, are also presented below for persons aged 15 years or older to offer additional information. Very few HIV cases occur in persons younger than 15 years, but the population in the younger age groups is large and unevenly distributed across the different racial/ethnic populations. Additionally, the proportions of females and males differ across these populations.

Table 9. Cumulative HIV Cases (with and without AIDS) in Males Aged 15 Years and Older at First HIV Diagnosis, by Race/Ethnicity through December 31, 2005, and 2005 Alaska Male Population Aged 15 Years and Older

Race/Ethnicity	HIV Cases First Diagnosed in Males \geq 15 Years of Age		Males \geq 15 Years of Age, Alaska Population*	
	Number	% Total	Number	% Total
White	511	61%	195,927	76%
Alaska Native/American Indian	168	20%	40,709	16%
Black	70	8%	9,772	4%
Asian/Pacific Islander	15	2%	11,890	5%
Hispanic Ethnicity	62	7%	[8,817]**	[3%]**
Unknown Race	10	1%	---	---
Total	836	100%	258,298	100%

* Population data are from the Alaska Department of Labor and Workforce Development's Alaska State Race Bridged Smooth Series estimates for July 1, 2005

**Males \geq 15 years of Hispanic/Latino ethnicity are included within the race categories in the population data, as well as shown separately

Compared to their distributions in the overall Alaska population, Alaska Native/American Indian, Black, and Hispanic males were over-represented, and White and Asian/Pacific Islander males were under-represented, among cumulative cases of HIV infection in adult/adolescent males.

Table 10. Cumulative HIV Cases (with and without AIDS) in Females Aged 15 Years and Older at First HIV Diagnosis, by Race/Ethnicity through December 31, 2005, and 2005 Alaska Female Population Aged 15 Years and Older

Race/Ethnicity	HIV Cases first Diagnosed in Females \geq 15 Years of Age		Females \geq 15 Years of Age, Alaska Population*	
	Number	% Total	Number	% Total
White	87	44%	180,991	74%
Alaska Native/American Indian	67	34%	40,826	17%
Black	26	13%	9,241	4%
Asian/Pacific Islander	5	3%	14,056	6%
Hispanic Ethnicity	10	5%	[8,662]**	[4%]**
Unknown Race	3	2%	---	---
Total	198	100%	245,114	100%

*Population data are from the Alaska Department of Labor and Workforce Development's Alaska State Race Bridged Smooth Series estimates for July 1, 2005

**Females \geq 15 years of Hispanic/Latino ethnicity are included within the race categories in the population data, as well as shown separately

Compared to their distributions in the overall Alaska population, Alaska Native/American Indian, Black, Asian/Pacific Islander, and Hispanic females were over-represented, and White females were under-represented, among cumulative cases of HIV infection in adult/adolescent females.

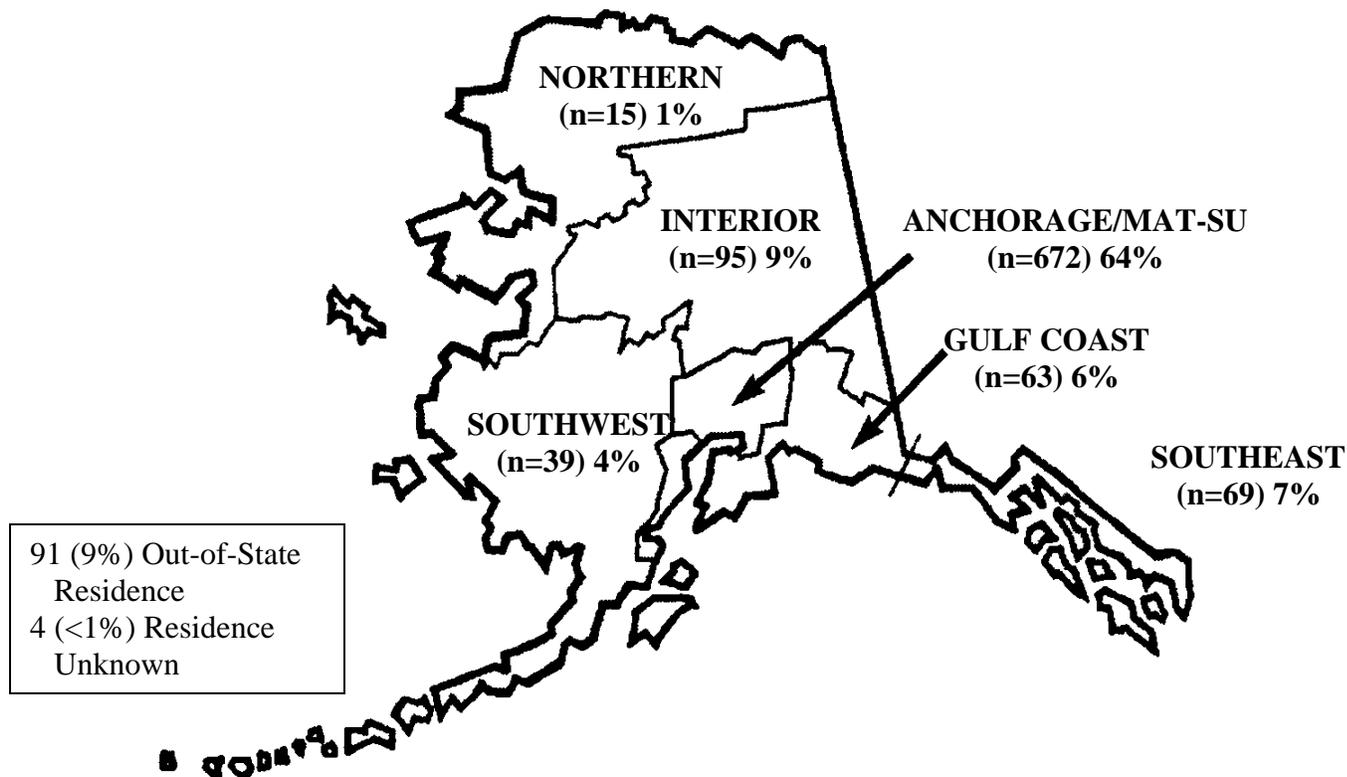
Geographic Region of Residence at First HIV Diagnosis in Alaska

HIV cases were reported from all regions of the state. At the time of their first HIV diagnosis in Alaska, 672 cases (64%) had a reported residence of Anchorage/Mat Su, the most populous region of the state (53% of the state population resided in the Anchorage/Mat Su region in 2005). A total of 747 cases (71%) resided in the urban areas of Anchorage, Fairbanks or Juneau (60% of the state's 2005 population) at the time of their first HIV/AIDS diagnosis in Alaska.

Geographic region of residence at the time of first HIV/AIDS diagnosis in Alaska is shown in Figure 7 and Table 11 for cumulative cases of HIV/AIDS reported through December 31, 2005. The region of residence is defined as the region where the person resided at the time of first known HIV diagnosis, when known. If this is not known, residence is defined as the region of residence at the time of first AIDS diagnosis. If neither of these is known, residence is defined as the region from which the earliest case report was received. The geographic areas identified represent the state's economic regions.

HIV infection is generally asymptomatic for a long period after initial infection, and the population is highly mobile. These data must therefore be interpreted with caution. Residence at first known HIV diagnosis does not necessarily reflect the area where infection occurred or the area where the infected individual currently resides or seeks care, if still living.

Figure 7. Region of Residence* at Time of First HIV/AIDS Diagnosis in Alaska, Cumulative Cases Reported through December 31, 2005, Alaska N=1,048



*Note: Region of residence is defined as region of residence at first HIV diagnosis, when known, the region of residence at first AIDS diagnosis when the residence at HIV diagnosis is unknown, and the region of first case report when residence at HIV and AIDS diagnosis are unknown

Table 11. Estimated Population by Geographic Region* and Cumulative Number of Cases by Region of Residence at First HIV/AIDS Diagnosis in Alaska, Diagnosis through December 31, 2005 Alaska (N=1,048)

Region	HIV Cases		Population	
	Number	(% Total)	Number	(% Total)
Southwest	39	4%	39,979	6%
Northern	15	1%	23,669	4%
Interior	95	9%	102,005	15%
Anchorage/Mat-Su	672	64%	352,282	53%
Gulf Coast	63	6%	74,904	11%
Southeast	69	7%	70,822	11%
Out of State	91	9%	---	---
Unknown	4	<1%	---	---
Total	1,048	100%	663,661	100%

*Population estimates by the Alaska Department of Labor and Workforce Development as of June 30, 2005

RECENTLY INFECTED HIV CASES COMPARED TO EARLIER CASES

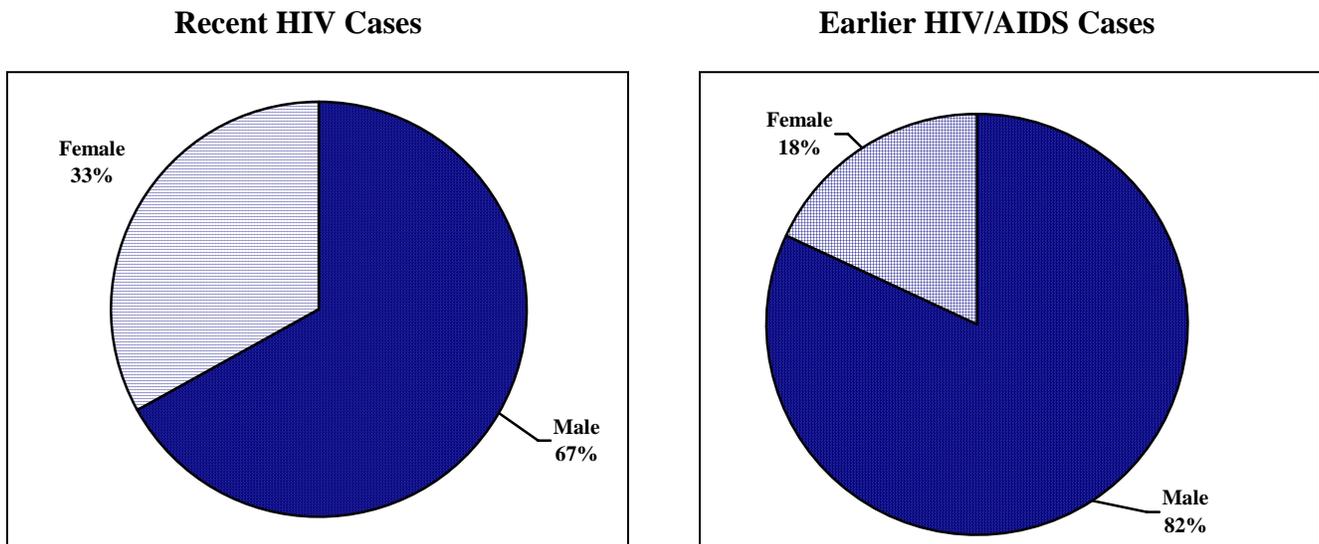
Characteristics of cases infected with HIV more recently may differ from those infected in years past, potentially indicating changes in populations at risk. In order to allow for comparison, given the small case numbers in Alaska, data on HIV infections that were first diagnosed within the past 5 years (2001-2005) and that had not progressed to AIDS were selected as indicators of recent infections. In the following tables and graphs, data on “recent” cases of HIV infection are compared to data on all cases of HIV without AIDS diagnosed prior to 2001 and all cases with AIDS (“earlier” cases).

Gender

Male – Of the 118 recent cases, 79 (67%) were in males. Of 930 earlier cases, 767 (82%) were in males.

Female - Of the 118 recent cases, 39 (33%) were in females. Of 930 earlier cases, 163 (18%) were in females.

Figure 8. Proportion of HIV Cases by Gender, Recent HIV and Earlier HIV/AIDS Cases (N=1,048, 118 Recent and 930 Earlier Cases)



Females made up a larger proportion of recent than earlier cases (33% as compared to 18%). The proportion of males (67%) was slightly less, and the proportion of females slightly greater (33%) among recent cases reported in Alaska than in cases of HIV without AIDS reported in 2004 in the 42 U.S. areas with confidential name-based HIV reporting (70% and 30%, respectively, CDC 2004 HIV/AIDS Surveillance Report, p.9).

Age

Cases in males diagnosed more recently tended to be slightly older than earlier cases. The age distribution of recent female cases appears very similar to that of earlier cases.

Table 12. Age Distribution for Recent HIV vs. Earlier HIV/AIDS Cases in Males through December 31, 2005, Alaska (N=846, 79 Recent and 767 Earlier Cases)

Age Group	Recent Male HIV Cases		Earlier Male HIV/AIDS Cases		Total Male Cases	
	Number	Column %	Number	Column %	Number	Column %
00-04	0	0%	5	1%	5	1%
05-09	0	0%	1	<1%	1	<1%
10-14	1	1%	2	<1%	3	<1%
15-19	1	1%	11	1%	12	1%
20-24	7	9%	77	10%	84	10%
25-29	8	10%	142	19%	150	18%
30-34	13	16%	164	21%	177	21%
35-39	10	13%	141	18%	151	18%
40-44	20	25%	116	15%	136	16%
45-49	11	14%	56	7%	67	8%
50-54	3	4%	24	3%	27	3%
55-59	4	5%	12	2%	16	2%
60-64	1	1%	9	1%	10	1%
65+	0	0%	6	1%	6	1%
Unknown	0	0%	2	<1%	1	<1%
Total	79	100%	767	100%	846	100%

Figure 8. Age Distribution for Recent HIV vs. Earlier HIV/AIDS Cases in Males through December 31, 2005, Alaska (N=846, 79 Recent and 767 Earlier Cases; 1 case with unknown age at diagnosis is not included)

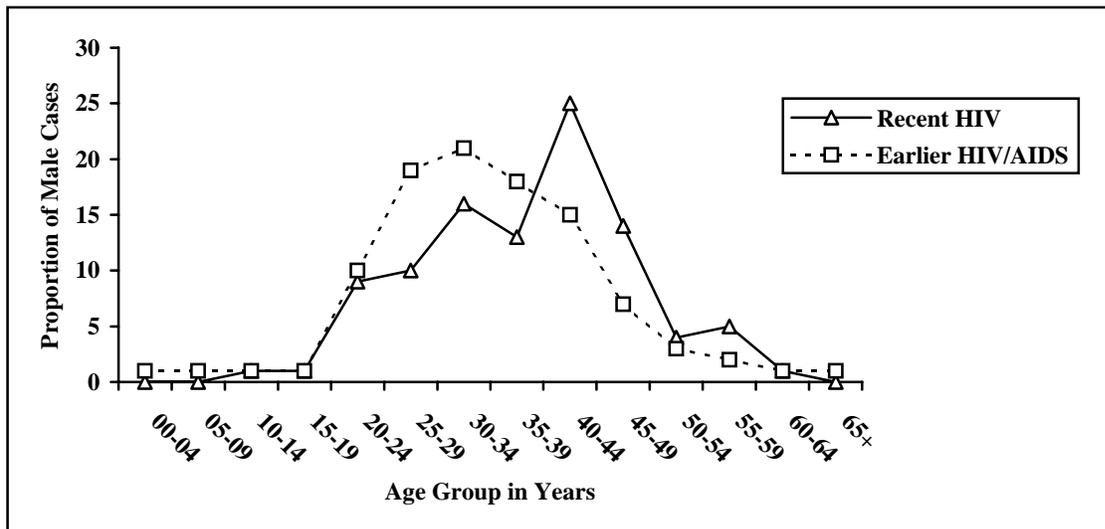
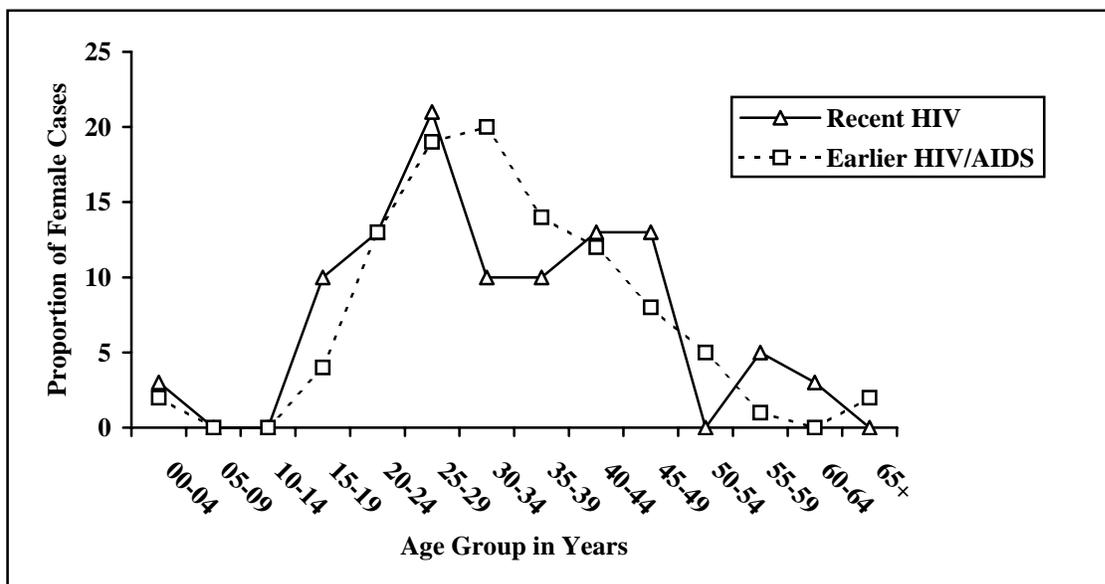


Table 13. Age Distribution for Recent HIV vs. Earlier HIV/AIDS Cases in Females through December 31, 2005, Alaska (N=202, 39 Recent and 163 Earlier Cases)

Age Group	Recent Female HIV Cases		Earlier Female HIV/AIDS Cases		Total Female Cases	
	Number	Column %	Number	Column %	Number	Column %
00-04	1	3%	3	2%	4	2%
05-09	0	0%	0	0%	0	0%
10-14	0	0%	0	0%	0	0%
15-19	4	10%	7	4%	11	5%
20-24	5	13%	22	13%	27	13%
25-29	8	21%	31	19%	39	19%
30-34	4	10%	33	20%	37	18%
35-39	4	10%	23	14%	27	13%
40-44	5	13%	19	12%	24	12%
45-49	5	13%	13	8%	18	9%
50-54	0	0%	8	5%	8	4%
55-59	2	5%	1	1%	3	1%
60-64	1	3%	0	0%	1	<1%
65+	0	0%	3	2%	3	1%
Unknown	0	0%	0	0%	0	0%
Total	39	100%	163	100%	202	100%

Figure 9. Age Distribution for Recent HIV vs. Earlier HIV/AIDS Cases in Females through December 31, 2005, Alaska (N=202, 39 Recent and 163 Earlier Cases)



Transmission Risk

Males. Transmission risk for the greatest proportion of recent and earlier cases in males was male-to-male sexual contact, but the proportion decreased for recent (53%) as compared to earlier (60%) cases. The proportion of cases with injection drug use as the transmission risk was greater for recent (16%) than for earlier (11%) male cases. The proportion of cases with combined MSM and IDU transmission risk decreased for recent (3%) as compared to earlier (9%) male cases. The proportion of cases with heterosexual transmission risk increased for recent (15%) as compared to earlier (5%) male cases. No recent male cases were reported with risks related to transfusion/transplant, hemophilia, or perinatal transmission.

Table 14. Transmission Category for Recent HIV vs. Earlier HIV/AIDS Cases in Males through December 31, 2005, Alaska (N=846, 79 Recent and 767 Earlier Cases)

Transmission Category	Recent Male HIV Cases		Earlier Male HIV/AIDS Cases		Total Male Cases	
	Number	Column %	Number	Column %	Number	Column %
Male-to-Male Sexual Contact (MSM)	42	53%	459	60%	501	59%
Injection Drug Use (IDU)	13	16%	87	11%	100	12%
MSM and IDU	2	3%	68	9%	70	8%
Heterosexual Contact to At-Risk Person	12	15%	39	5%	51	6%
Transfusion/Transplant	0	0%	10	1%	10	1%
Hemophilia	0	0%	10	1%	10	1%
Perinatal Transmission	0	0%	3	<1%	3	<1%
No Risk Reported/Identified	10	13%	91	12%	101	12%
Total	79	100%	767	100%	846	100%

Females. Transmission risk for the greatest proportion of recent and earlier cases in females was heterosexual contact to a person with or at increased risk for HIV, and the proportion increased for recent (54%) as compared to earlier (51%) cases. The proportion of cases with injection drug use as the transmission risk decreased for recent (21%) as compared to earlier (23%) female cases. One recent female case was reported with perinatal transmission and none with risks related to transfusion/transplant or hemophilia.

Table 15. Transmission Category for Recent HIV vs. Earlier HIV/AIDS Cases in Females through December 31, 2005, Alaska (N=202, 39 Recent and 163 Earlier Cases)

Transmission Category	Recent Female HIV Cases		Earlier Female HIV/AIDS Cases		Total Female Cases	
	Number	Column %	Number	Column %	Number	Column %
Male-to-Male Sexual Contact (MSM)	N/A	N/A	N/A	N/A	NA	NA
Injection Drug Use (IDU)	8	21%	37	23%	45	22%
MSM and IDU	N/A	N/A	N/A	N/A	NA	NA
Heterosexual Contact to At-Risk Person	21	54%	83	51%	104	51%
Transfusion/Transplant	0	0%	3	2%	3	1%
Hemophilia	0	0%	0	0%	0	0%
Perinatal Transmission	1	3%	3	2%	4	2%
No Risk Reported/Identified	9	23%	37	23%	46	23%
Total	39	100%	163	100%	202	100%

Race/Ethnicity

Males. Whites constituted the greatest proportion of recent and earlier cases in males, but the proportion of White cases was less for recent (51%) than in earlier (62%) cases. For males of all other races and Hispanic ethnicity, the proportion of cases was greater for recent than earlier cases: Alaska Native/American Indian males constituted 25% of recent and 20% of earlier cases; Black males constituted 10% of recent and 8% of earlier cases; Asian/Pacific Islander males constituted 6% of recent and 1% of earlier cases; and Hispanic males constituted 8% of recent and 7% of earlier cases.

Table 16. Race/Ethnicity of Recent HIV vs. Earlier HIV/AIDS Cases in Males through December 31, 2005, Alaska (N=846, 79 Recent and 767 Earlier Cases)

Race/Ethnicity	Recent Male HIV Cases		Earlier Male HIV/AIDS Cases		Total Male Cases	
	Number	Column %	Number	Column %	Number	Column %
White	40	51%	478	62%	518	61%
Alaska Native/ American Indian	20	25%	150	20%	170	20%
Black	8	10%	63	8%	71	8%
Asian/Pacific Islander	5	6%	10	1%	15	2%
Hispanic Ethnicity	6	8%	56	7%	62	7%
Unknown Race/Ethnicity	0	0%	10	1%	10	1%
Total	79	100%	767	100%	846	100%

Females. Whites constituted the greatest proportion of recent and earlier cases in females, and the proportion increased in recent (56%) as compared to earlier (40%) cases. The proportion of cases in Alaska Natives/American Indians decreased in recent (28%) as compared to earlier (35%) female cases. The proportion of cases in Blacks was the same in recent (13%) and earlier female cases. The proportion of cases in Hispanics decreased in recent (3%) as compared to earlier (6%) female cases. No recent cases were reported in Asian/Pacific Islander females.

Table 17. Race/Ethnicity of Recent HIV vs. Earlier HIV/AIDS Cases in Females through December 31, 2005, Alaska (N=202, 39 Recent and 163 Earlier Cases)

Race/Ethnicity	Recent Female HIV Cases		Earlier Female HIV/AIDS Cases		Total Female Cases	
	Number	Column %	Number	Column %	Number	Column %
White	22	56%	66	40%	88	44%
Alaska Native/ American Indian	11	28%	57	35%	68	34%
Black	5	13%	22	13%	27	13%
Asian/Pacific Islander	0	0%	5	3%	5	2%
Hispanic Ethnicity	1	3%	10	6%	11	5%
Unknown Race/Ethnicity	0	0%	3	2%	3	1%
Total	39	100%	163	100%	202	100%

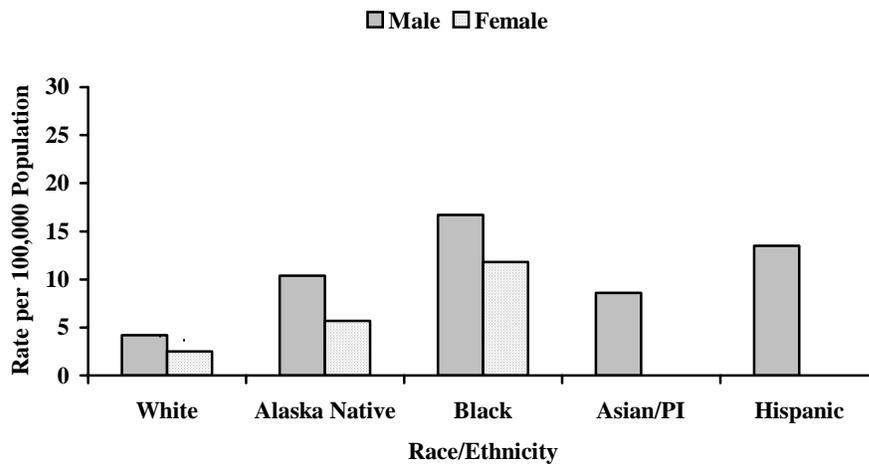
Race is one of the few characteristics where estimates of the various populations' sizes are available (in contrast to populations of MSM, injectors, etc.). In Table 18 and Figure 10 below, rates by gender for each race, and separately for those of Hispanic ethnicity, are provided for recent HIV cases aged 15 years and older. Since not every case of HIV infection is likely to have been diagnosed, the rates calculated can be considered estimates of the true rates.

Table 18. HIV Incidence Rates, Alaska, Recent HIV Infections in Adolescents/Adults ≥ 15 Years by Gender and Race/Ethnicity* (N=117)

Race/Ethnicity Category, Cases ≥ 15 Years	Rate per 100,000 Population*
White Male	4.2
White Female	2.5
Alaska Native/American Indian Male	10.4
Alaska Native/American Indian Female	5.7
Black Male	16.7
Black Female	11.8
Asian/Pacific Islander Male	8.6
Asian/Pacific Islander Female	N/A
Hispanic Male	13.5
Hispanic Female	N/A

*Individuals of Hispanic ethnicity are counted within race populations in calculating the rates by race, and are also counted separately in calculating the rate for males and females of Hispanic ethnicity

Figure 10. HIV Incidence Rates, Alaska, Recent HIV Infections in Adolescents/Adults ≥ 15 Years by Gender and Race/Ethnicity* (N= 117)



*Individuals of Hispanic ethnicity are counted within race populations in calculating the rates by race, and are also counted separately in calculating the rate for males and females of Hispanic ethnicity

Residence at First HIV Diagnosis in Alaska

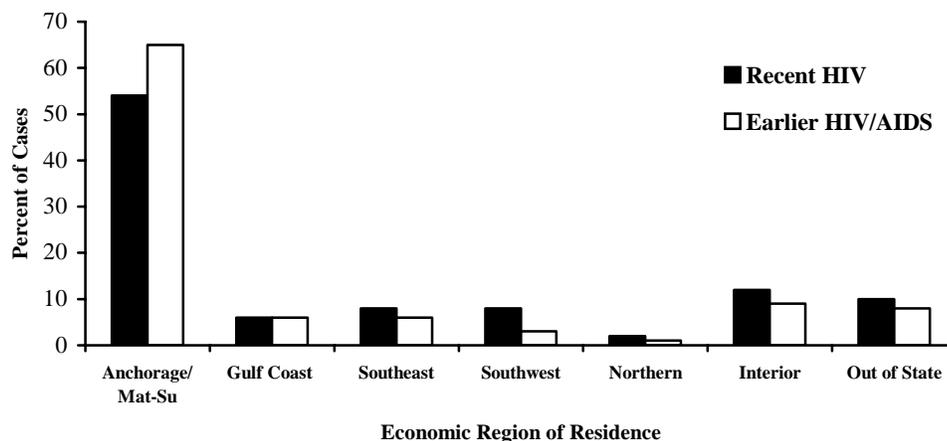
Data are presented below on the distribution of recent HIV and earlier HIV/AIDS cases across economic regions and rural/urban areas at the time of first HIV diagnosis in Alaska.

Economic Regions. The largest proportion of all recent HIV (54%) and earlier HIV/AIDS (65%) cases were in persons who resided in the Anchorage/Mat-Su region at the time of first HIV diagnosis in Alaska, although the proportion of recent cases with this residence was less than that of earlier cases. The proportion of recent cases residing in all other regions at first Alaska diagnosis increased compared to earlier cases, except for the Gulf Coast region, in which the proportions of recent and earlier cases remained the same. The proportion of recent cases with out-of-state residence was greater in recent than earlier cases.

Table 19. Economic Region of Residence at First HIV Diagnosis in Alaska, Recent HIV and Earlier HIV/AIDS Cases (N=1,048; 118 Recent and 930 Earlier)

Economic Region	Recent		Earlier		Total	
	Number	Column %	Number	Column %	Number	Column %
Anchorage/Mat-Su	64	54%	608	65%	672	64%
Gulf Coast	7	6%	56	6%	63	6%
Southeast	9	8%	60	6%	69	7%
Southwest	10	8%	29	3%	39	4%
Northern	2	2%	13	1%	15	1%
Interior	14	12%	81	9%	95	9%
Out of State	12	10%	79	8%	91	8%
Unknown	0	0%	4	<1%	4	<1%
Total	118	100%	930	100%	1,048	100%

Figure 11. Economic Region of Residence at First HIV Diagnosis in Alaska, Recent HIV and Earlier HIV/AIDS Cases (N= 1,048; 118 Recent and 930 Earlier)
(4 [$<1\%$] earlier cases with unknown residence not included)



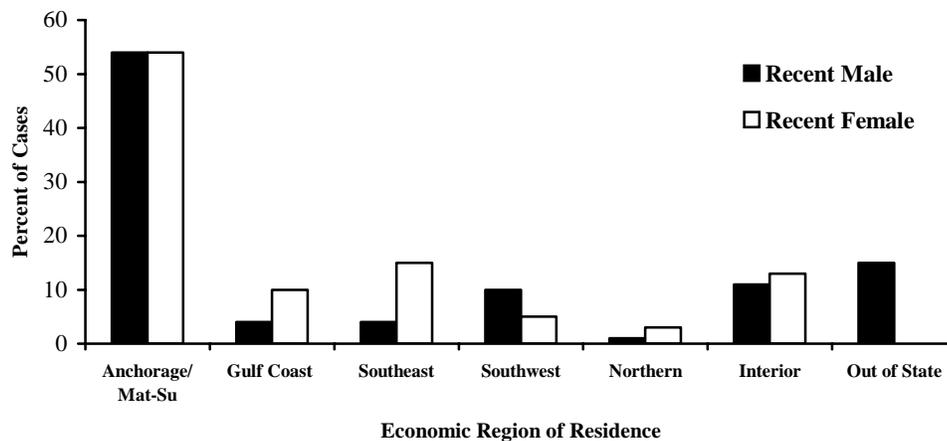
Economic Region by Gender. The largest proportion of all recent HIV cases in males and females (54%) resided in Anchorage/Mat-Su at the time of first HIV diagnosis in Alaska, and was the same for both genders. A greater proportion of recent male cases than recent female

cases resided in Southwest Alaska or Out of State at the time of first diagnosis in Alaska. In all other regions, the proportion of female cases that resided there at time of first diagnosis in Alaska was greater than the proportion of male cases.

Table 20. Economic Region of Residence at First HIV Diagnosis in Alaska, Recent HIV Cases by Gender (N=118; 79 Male and 39 Female)

Economic Region	Male		Female		Total	
	Number	Column %	Number	Column %	Number	Column %
Anchorage/Mat-Su	43	54%	21	54%	64	54%
Gulf Coast	3	4%	4	10%	7	6%
Southeast	3	4%	6	15%	9	8%
Southwest	8	10%	2	5%	10	8%
Northern	1	1%	1	3%	2	2%
Interior	9	11%	5	13%	14	12%
Out of State	12	15%	0	0%	12	10%
Unknown	0	0%	0	0%	0	0%
Total	79	100%	39	100%	118	100%

Figure 12. Economic Region of Residence at First HIV Diagnosis in Alaska, Recent HIV Cases by Gender (N= 118; 79 Male and 39 Female)



Males. The largest proportion of HIV cases in males resided in Anchorage/Mat-Su at the time of first HIV diagnosis in Alaska. The proportion of such cases was smaller for recent (54%) than earlier (67%) cases, as was the proportion of male cases with first diagnosis in the Gulf Coast (4% of recent and 6% of earlier cases), and Southeast regions (4% of recent and 7% of earlier cases). The proportion of cases residing in the Northern region (3%) at time of first diagnosis in Alaska was the same in recent and earlier male cases. Greater proportions of recent than earlier male cases resided in Southwest (10% of recent and 3% of earlier cases) and Interior regions (11% of recent and 8% of earlier cases), and Out of State (15% of recent and 6% of earlier cases) at the time of first HIV diagnosis in Alaska.

Table 21. Economic Region of Residence at First HIV Diagnosis in Alaska, Recent Male HIV and Earlier Male HIV/AIDS Cases (N=846; 79 Recent and 767 Earlier)

Economic Region	Recent Male Cases		Earlier Male Cases		Total Male Cases	
	Number	Column %	Number	Column %	Number	Column %
Anchorage/Mat-Su	43	54%	512	67%	555	66%
Gulf Coast	3	4%	43	6%	46	5%
Southeast	3	4%	51	7%	54	6%
Southwest	8	10%	21	3%	29	3%
Northern	1	1%	8	1%	9	1%
Interior	9	11%	67	9%	71	8%
Out of State	12	15%	67	9%	79	9%
Unknown	0	0%	3	<1%	3	<1%
Total	79	100%	767	100%	846	100%

Females. The largest proportion of HIV cases in females resided in Anchorage/Mat-Su at the time of first HIV diagnosis in Alaska. The proportion of such cases was greater for earlier HIV/AIDS (59%) than recent HIV (54%) cases, as was the proportion of cases residing Out of State (7% of earlier female cases and 0% of recent cases). The proportions of cases residing in Southwest (5%) and Northern (3%) regions at time of first diagnosis in Alaska were the same in recent and earlier female cases. Greater proportions of recent than earlier female cases resided in the Gulf Coast (10% of recent and 8% of earlier cases), Southeast (15% of recent and 6% of earlier cases), and Interior regions (13% of recent and 12% of earlier cases) at time of first diagnosis in Alaska.

Table 22. Economic Region of Residence at First HIV Diagnosis in Alaska, Recent Female HIV and Earlier Female HIV/AIDS Cases (N=202; 39 Recent and 163 Earlier)

Economic Region	Recent Female Cases		Earlier Female Cases		Total Female Cases	
	Number	Column %	Number	Column %	Number	Column %
Anchorage/Mat-Su	21	54%	96	59%	117	58%
Gulf Coast	4	10%	13	8%	17	8%
Southeast	6	15%	9	6%	15	7%
Southwest	2	5%	8	5%	10	5%
Northern	1	3%	5	3%	6	3%
Interior	5	13%	19	12%	24	12%
Out of State	0	0%	12	7%	12	6%
Unknown	0	0%	1	1%	1	<1%
Total	39	100%	163	100%	202	100%

Urban/Rural Residence. To further geographically characterize HIV infection, the distribution of cases is also presented below across four geographic categories: (1) Urban Centers, combining Anchorage, Fairbanks, and Juneau; (2) Sub-urban Areas, combining the Matanuska-Susitna and Kenai Peninsula Boroughs and excluding villages not connected to Anchorage on the road system; (3) Rural Hubs, including the thirteen economic and transportation centers in the rural regions of Alaska and Southeast Alaska with populations over 2,000; and (4) Rural Communities, including the 260 incorporated and unincorporated cities, census designated

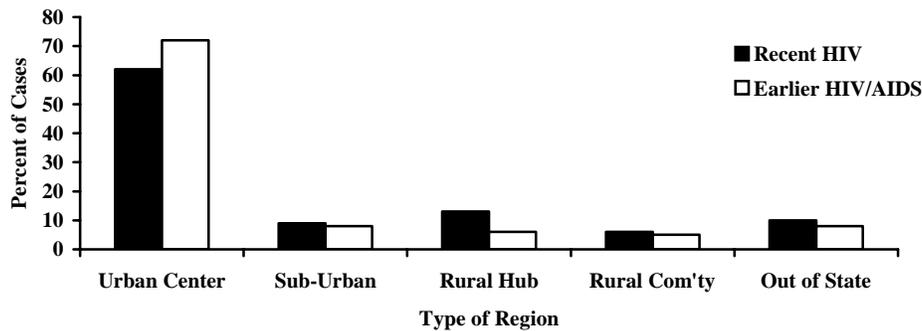
places, and Alaska Native Villages outside of the other categories as well as persons living outside of any community.

The largest proportion of HIV cases resided in Urban areas at the time of first HIV diagnosis in Alaska, but the proportion declined in recent HIV cases (62%) as compared to earlier HIV/AIDS (72%) cases. The proportions of recent and earlier cases were the same in Sub-urban areas, while greater proportions of recent than earlier cases resided in all other areas at first diagnosis.

Table 23. Urban/Rural Area of Residence at First HIV Diagnosis in Alaska, Recent HIV and Earlier HIV/AIDS Cases (N=1,048; 118 Recent and 930 Earlier Cases)

Urban/Rural Area	Recent		Earlier		Total	
	Number	Column %	Number	Column %	Number	Column %
Urban	73	62%	674	72%	747	71%
Sub-Urban	11	9%	70	8%	81	8%
Rural Hub	15	13%	52	6%	67	6%
Rural Community	7	6%	51	5%	58	6%
Out of State	12	10%	79	8%	91	9%
Unknown Residence	0	0%	4	<1%	4	<1%
Total	118	100%	930	100%	1,048	100%

Figure 13. Urban/Rural Area of Residence at First HIV Diagnosis in Alaska, Recent HIV and Earlier HIV/AIDS Cases (N= 1,048; 118 Recent and 930 Earlier; 4 [$<1\%$] earlier cases have unknown region of residence)

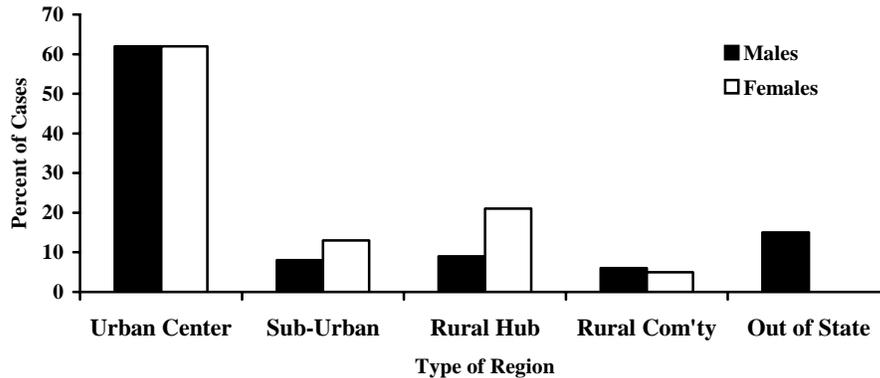


Urban/Rural Area by Gender. The largest proportions of recent male and female HIV cases resided in an Urban area at the time of first Alaska HIV diagnosis (both 62%). The proportion of females (13%) with Sub-urban residence at diagnosis was greater than that of males (8%), as was the proportion with residence in Rural Hubs (21% of female cases, 9% of male cases). A larger proportion of male cases resided in Rural Communities or Out of State at time of first diagnosis (6% and 15%, respectively) than did female cases (5% and 0%, respectively).

Table 24. Urban/Rural Area of Residence at First HIV Diagnosis in Alaska by Gender, All Recent HIV Cases (N=118; 79 Males and 39 Females)

Urban/Rural Area	Male		Female		Total	
	Number	Column %	Number	Column %	Number	Column %
Urban	49	62%	24	62%	73	62%
Sub-Urban	6	8%	5	13%	11	9%
Rural Hub	7	9%	8	21%	15	13%
Rural Community	5	6%	2	5%	7	6%
Out of State	12	15%	0	0%	12	10%
Unknown Residence	0	0%	0	0%	0	0%
Total	79	100%	39	100%	118	100%

Figure 14. Urban/Rural Area of Residence at First HIV Diagnosis in Alaska by Gender, Recent HIV Cases (N= 118; 79 Males and 39 Females)



Males. The largest proportions of recent HIV and earlier HIV/AIDS cases in males resided in an Urban area at the time of first HIV diagnosis, and this proportion declined for recent (62%) as compared to earlier (74%) cases. Proportions of recent male HIV cases with first diagnosis in all other areas of residence increased as compared to earlier male cases.

Table 25. Region of Residence at First HIV Diagnosis in Alaska, Recent HIV and Earlier Male HIV/AIDS Cases (N=846; 79 Recent and 767 Earlier)

Region	Recent Male		Earlier Male		Total Male	
	Number	Column %	Number	Column %	Number	Column %
Urban	49	62%	569	74%	618	73%
Sub-Urban	6	8%	54	7%	60	7%
Rural Hub	7	9%	39	5%	46	5%
Rural Community	5	6%	35	5%	40	5%
Out of State	12	15%	67	9%	79	9%
Unknown Residence	0	0%	3	<1%	3	<1%
Total	79	100%	767	100%	846	100%

Females. The largest proportions of recent HIV and earlier HIV/AIDS cases in females resided in an Urban area at the time of first HIV diagnosis, and this proportion declined for recent (62%) as compared to earlier (64%) cases. Proportions of recent female HIV cases with residence in Sub-urban (13%) and Rural Hub (21%) areas at first HIV diagnosis increased as compared to earlier cases (10% and 8%, respectively). Female cases with residence at diagnosis in Rural Communities and Out of State decreased in recent (5% and 0%, respectively) as compared to earlier cases (10% and 7%, respectively).

Table 26. Urban/Rural Area of Residence at First HIV Diagnosis in Alaska, Recent Female HIV and Earlier Female HIV/AIDS Cases (N=202; 39 Recent and 163 Earlier)

Urban/Rural Area	Recent Female		Earlier Female		Total Female	
	Number	Column %	Number	Column %	Number	Column %
Urban	24	62%	105	64%	129	64%
Sub-Urban	5	13%	16	10%	21	10%
Rural Hub	8	21%	13	8%	21	10%
Rural Community	2	5%	16	10%	18	9%
Out of State	0	0%	12	7%	12	6%
Unknown Residence	0	0%	1	1%	1	<1%
Total	39	100%	163	100%	202	100%

HIV CASES PRESUMED TO BE LIVING

Data on the number of persons living with HIV in a given area, or the *prevalence* of HIV infection in that area, provide one indicator of potential service needs. The true number and characteristics of persons living with HIV in Alaska can only be approximated for a number of reasons: some infected persons are unaware of their infection (they have not been diagnosed), not all diagnosed cases have yet been reported, some reported cases no longer live here, and some out-of-state deaths in cases with prior Alaska residence are not reflected in case data. (Of the 704 persons reported with HIV/AIDS in Alaska since 1982 and who are not known to have died, 94 were diagnosed prior to 1990.) The most straightforward approximation of HIV prevalence is provided by the number of persons with HIV reported in Alaska who are not known to have died. Data on the characteristics of these individuals (referred to below as “presumed living” and “PLWHIV”) are presented below.

Characteristics of persons living with HIV/AIDS (PLWHIV) in Alaska are similar to U.S. trends among persons living with HIV/AIDS, except for race/ethnicity. Data on transmission categories are difficult to compare because the CDC estimates redistribute cases with “no risk identified” into the other transmission categories according to statistical models, while these cases are shown separately in the Alaska data. The U.S. trends presented are estimates based on data from the 35 areas with confidential name-based HIV infection reporting since 2000, and are presented in CDC’s 2004 *HIV/AIDS Surveillance Report* (p.7).

- Of all PLWHIV, 78% of cases reported in Alaska were male, and 73% of U.S. adult/adolescent cases were male.

- The largest single proportion of PLWHIV in Alaska and in the U.S. was in the age group of 40-44 years (22% for each).
- Of male PLWHIV, 56% of Alaska and 60% of U.S. cases were in MSM; 14% of Alaska and 19% of U.S. cases were in IDU; 7% of Alaska and 13% of U.S. cases were exposed through heterosexual contact; and 8% of Alaska and 7% of U.S. cases were in MSM who also were IDU.
- Of female PLWHIV, 55% of Alaska and 71% of U.S. PLWHIV were exposed through heterosexual contact; and 18% of Alaska and 27% of U.S. PLWHIV were exposed through IDU.
- The proportions of the Alaska population by race differ from those of the U.S., and proportions of PLWHIV likewise differ: 58% of Alaska and 34% of U.S. PLWHIV were White; 23% of Alaska and less than 1% of U.S. PLWHIV were Alaska Native/American Indian; 9% of Alaska and 48% of U.S. PLWHIV were Black; 7% of Alaska and 17% of U.S. PLWHIV were Hispanic; and 2% of Alaska and less than 1% of U.S. PLWHIV were Asian/Pacific Islander.

Gender

Of the 704 HIV/AIDS cases presumed living as of December 31, 2005, 547 (78%) were male and 157 (22%) were female.

Table 27. Gender of Cases Presumed Living and Known Dead as of December 31, 2005, Alaska (N=1,048)

Gender	Cases Presumed Living		Cases Known to Have Died		Total HIV/AIDS Cases	
	Number	Column %	Number	Column %	Number	Column %
Male	547	78%	299	87%	846	81%
Female	157	22%	45	13%	202	19%
Total	704	100%	344	100%	1,048	100%

Age

In the table below, age is calculated as of December 31, 2005. (Note that this differs from other age tables in this document that present age at time of first HIV diagnosis.)

Table 28. Age Distribution for Cases Presumed Living as of December 31, 2005 (N=704)

Age Group	Cases Presumed Living	
	Number	Column %
00-04	2	<1%
05-09	0	0%
10-14	1	<1%
15-19	3	<1%
20-24	10	1%
25-29	37	5%
30-34	65	9%
35-39	120	17%
40-44	157	22%
45-49	143	20%
50-54	86	12%
55-59	49	7%
60-64	17	2%
65+	14	2%
Unknown	0	0%
Total	704	100%

Transmission Category

Table 29. Transmission Category for HIV/AIDS Cases Presumed Living and Those Known to Have Died through December 31, 2005 (N=1,048)

Transmission Category	Cases Presumed Living		Cases Known to Have Died		Total HIV/AIDS Cases	
	Number	Column %	Number	Column %	Number	Column %
Male-to-Male Sexual Contact (MSM)	307	44%	194	56%	501	48%
Injection Drug Use (IDU)	105	15%	40	12%	145	14%
MSM and IDU	46	7%	24	7%	70	7%
Heterosexual Contact to At-Risk Person	128	18%	27	8%	155	15%
Transfusion/Transplant	1	<1%	12	3%	13	1%
Hemophilia	4	1%	6	2%	10	1%
Perinatal Transmission	2	<1%	5	1%	7	1%
No Risk Reported/ Identified	111	16%	36	10%	147	14%
Total	704	100%	344	100%	1,048	100%

Table 30. Transmission Category by Gender for HIV/AIDS Cases Presumed Living through December 31, 2005 (N=704; 547 Males and 157 Females))

Transmission Category	Male Cases Presumed Living		Female Cases Presumed Living		Total Cases Presumed Living	
	Number	Column %	Number	Column %	Number	Column %
Male-to-Male Sexual Contact (MSM)	307	56%	N/A	N/A	307	44%
Injection Drug Use (IDU)	76	14%	29	18%	105	15%
MSM and IDU	46	8%	N/A	N/A	46	7%
Heterosexual Contact to At-Risk Person	41	7%	87	55%	128	18%
Transfusion/Transplant	1	<1%	0	0%	1	<1%
Hemophilia	4	<1%	0	0%	4	1%
Perinatal Transmission	0	0%	2	1%	2	<1%
No Risk Reported/Identified	72	13%	39	25%	111	16%
Total	547	100%	157	100%	704	100%

Race/Ethnicity

Table 31. Race/Ethnicity of HIV/AIDS Cases Presumed Living and Those Known to Have Died through December 31, 2005 (N=1,048)

Race/Ethnicity	Cases Presumed Living		Cases Known to Have Died		Total HIV/AIDS Cases	
	Number	Column %	Number	Column %	Number	Column %
White	397	56%	209	61%	606	58%
Alaska Native/ American Indian	153	22%	85	25%	238	23%
Black	72	10%	26	8%	98	9%
Asian/Pacific Islander	16	2%	4	1%	20	2%
Hispanic Ethnicity	54	8%	19	6%	73	7%
Unknown Race/Ethnicity	12	2%	1	<1%	13	1%
Total	704	100%	344	100%	1,048	100%

PERSONS AGED 13-24 YEARS AT TIME OF DIAGNOSIS

Nationally, CDC has selected the age group of 13-24 years to characterize HIV infection in adolescents and young adults in the U.S. Through December 31, 2005, a cumulative total of 135 cases of HIV/AIDS were reported in Alaska in individuals aged 13-24 years at first HIV diagnosis (13% of the 1,048 cumulative HIV/AIDS cases). The proportion of HIV/AIDS cases first diagnosed from 2001-2005 in individuals 13-24 years of age (23 of 199 or 12%) is slightly less than the proportion first diagnosed in individuals in this age group from 1982-2000 (13%).

Of the 135 total cumulative cases in individuals aged 13-24 years at first HIV diagnosis, 97 (72%) cases were in males and 38 (28%) cases in females.

For males aged 13-24 years at first HIV diagnosis, male-to-male-sex, injection drug use, and male-male sex combined with injection drug use accounted for 90% of cases through December 2005. For females aged 13-24 years at first diagnosis, heterosexual contact to a person with or at increased risk of HIV infection was the most significant identified exposure risk (63% of cases), followed by injection drug use (11%). All races and ethnicities were represented in individuals aged 13-24 years at first HIV diagnosis, with the largest proportions of cases in White and Alaska Native males, and in White, Alaska Native, and Black females. The largest proportion of male and female cases resided in an Urban area of Alaska, with most residing in Anchorage/Mat-Su or Out of State at time of first HIV diagnosis.

Gender

Of the 135 HIV cases in individuals 13-24 years of age at first diagnosis, 97 (72%) were in males and 38 (28%) were in females. Of these 135 cases, 28 are known to have died. The year of first HIV diagnosis ranged from 1983-2005 for these cases.

Transmission Category

Table 32. Transmission Category for Individuals 13-24 Years of Age at First HIV Diagnosis through December 31, 2005 (N=135)

Transmission Category	Males		Females		Total	
	Number	Column %	Number	Column %	Number	Column %
Male-to-Male Sexual Contact (MSM)	64	66%	N/A	N/A	64	47%
Injection Drug Use (IDU)	8	8%	4	11%	12	9%
MSM and IDU	16	16%	N/A	N/A	16	12%
Heterosexual Contact to At-Risk Person	3	3%	24	63%	27	20%
Transfusion/Transplant	0	0%	0	0%	0	0%
Hemophilia	0	0%	0	0%	0	0%
Perinatal Transmission	0	0%	0	0%	0	0%
No Risk Reported/Identified	6	6%	10	26%	16	12%
Total	97	100%	38	100%	135	100%

Race/Ethnicity

Table 33. Race/Ethnicity of Individuals 13-24 Years of Age at First HIV Diagnosis through December 31, 2005 (N=135)

Race/Ethnicity	Males		Females		Total	
	Number	Column %	Number	Column %	Number	Column %
White	64	66%	16	42%	80	59%
Alaska Native/ American Indian	20	21%	12	32%	32	24%
Black	5	5%	7	18%	12	9%
Asian/Pacific Islander	0	0%	1	3%	1	1%
Hispanic Ethnicity	7	7%	2	5%	9	7%
Unknown Race/Ethnicity	1	1%	0	0%	1	1%
Total	97	100%	38	100%	135	100%

Table 34. Economic Region of Residence at First HIV Diagnosis in Alaska, Individuals 13-24 Years of Age at First HIV Diagnosis through December 31, 2005 (N=135)

Economic Region	Males		Females		Total	
	Number	Column %	Number	Column %	Number	Column %
Anchorage/Mat-Su	64	66%	19	50%	83	61%
Gulf Coast	3	3%	3	8%	6	4%
Southeast	4	4%	2	5%	6	4%
Southwest	3	3%	3	8%	6	4%
Northern	0	0%	1	3%	1	1%
Interior	6	6%	3	8%	9	7%
Out of State	17	18%	6	16%	23	17%
Unknown	0	0%	1	3%	1	1%
Total	97	100%	38	100%	135	100%

Table 35. Urban/Rural Area of Residence at First HIV Diagnosis in Alaska, Individuals 13-24 Years of Age at First HIV Diagnosis through December 31, 2005 (N=135)

Urban/Rural Area	Males		Females		Total	
	Number	Column %	Number	Column %	Number	Column %
Urban	70	72%	20	53%	90	67%
Sub-Urban	5	5%	3	8%	8	6%
Rural Hub	1	1%	4	11%	5	4%
Rural Community	4	4%	4	11%	8	6%
Out of State	17	18%	6	16%	23	17%
Unknown Residence	0	0%	1	3%	1	1%
Total	97	100%	38	100%	135	100%

HIV CASES FIRST REPORTED IN 2005

Forty-four (44) unduplicated cases of HIV were newly reported to the Alaska Division of Public Health in 2005, 30 (68%) diagnosed with HIV without AIDS and 14 (32%) with an AIDS diagnosis. Of the 44 newly reported cases, 28 (64%) had their first known HIV diagnosis in 2005, 15 (34%) had an earlier HIV diagnosis date, and one case had an unknown date of diagnosis.

The data below represent cases newly *reported* to the Division for the *first* time in 2005, and are not necessarily the same cases shown in Figure 2 and Table 3 as having been first *diagnosed* in 2005. These two sets of case numbers are expected to differ. For example, a case first diagnosed with AIDS in 2004 and reported for the first time in 2005 would be considered newly reported in 2005. A new AIDS diagnosis in 2005 in a case previously reported with HIV in 2000 would not be considered a newly reported case in 2005. Additionally, some individuals with an earlier HIV

diagnosis move to Alaska from other areas and are subsequently reported in Alaska for the first time.

Of the 30 cases of HIV without AIDS, 22 (73%) were first diagnosed in 2005, 7 (23%) were first diagnosed prior to 2005, and 1 (3%) case had an unknown date of diagnosis. Of the 14 cases first reported in 2005 with AIDS, 7 (50%) had their first AIDS diagnosis in 2005 and 7 (50%) were diagnosed with AIDS prior to 2005. Of the 14 cases newly reported with AIDS in 2005, 6 (43%) also had a first HIV diagnosis in 2005.

Table 36. Cases First Reported with HIV and/or AIDS in Alaska in 2005 (N=44)

Total reported with HIV and/or AIDS in 2005					44
Diagnosis of HIV (without AIDS)				30	
HIV diagnosis in 2005			22		
HIV diagnosis before 2005			7		
HIV diagnosis date unknown			1		
Diagnosis of AIDS				14	
AIDS diagnosis in 2005			7		
HIV diagnosis also in 2005		6			
HIV & AIDS diagnosed at same time	3				
HIV diagnosed in 2005 prior to AIDS	3				
HIV diagnosis prior to 2005			1		
AIDS diagnosis before 2005			7		

PERSONS DIAGNOSED LATE IN THE COURSE OF THEIR INFECTION

From 2001-2005, 60 of 165 (36%) persons with Alaska residence at first diagnosis developed AIDS within 12 months of their initial HIV diagnosis. This likely indicates diagnosis late in the course of their HIV disease, and late diagnosis limits an individual's potential benefit from medical care. Late diagnosis additionally indicates a lengthy period during which the infected person may have unknowingly transmitted HIV to others.

Of the 60 cases, 46% were in males and 14% in females. The largest proportion (45%) was in the age category 40-49 years at first HIV diagnosis; another 29% were between the ages of 25-34 years at first HIV diagnosis. Of the 60 cases, 45% were in Whites, 28% in Alaska Natives/American Indians, 10% in Blacks, 8% in Hispanics, and 8% in Asians/Pacific Islanders. Transmission risk for 38% of cases was MSM, for 28% heterosexual contact to a person at increased risk of HIV infection, for 12% injection drug use, for 8% MSM/IDU, and for 12% not specified.

Comparable data for the U.S. show that of all HIV infections diagnosed in 2003, 39% progressed to AIDS within 12 months after HIV infection was diagnosed. This occurred for a larger proportion of persons aged 35 years and older, IDUs, and persons exposed through heterosexual contact (CDC's 2004 *HIV/AIDS Surveillance Report*, p.6).

HIV CARE SERVICE UTILIZATION

The State of Alaska receives federal funding under Title II of the Ryan White CARE Act to purchase HIV care services for low income persons with HIV and their families as well as HIV medications. (Other in-state organizations including the Alaska Native Tribal Health Consortium, Anchorage Neighborhood Health Center, and the Yukon-Kuskokwim Health Corporation also receive federal funding under different titles of the CARE Act.)

In 2005, a total of 325 HIV-positive individuals received one or more services provided or purchased with CARE Act funds by one of the two State grantee organizations. These organizations have offices in Anchorage, Fairbanks, and Juneau and also serve individuals in other areas of the state. Of these 325 individuals, 37 (11%) were clients new to the service organizations during 2005. Males constituted 71% (230 individuals), females 29% (93 individuals), and transgender persons 1% (2 individuals) of the client population. Fifty individuals participated in the AIDS Drug Assistance Program.

Characteristics of individuals receiving services funded with Title II CARE Act funds are presented below.

Table 37. Demographic Characteristics of Title II CARE Act Clients in 2005

Characteristic	Title II CARE Act Service Clients, 2004 (N=325)
Gender	
Male	71%
Female	29%
Transgender	1%
Race	
White	52%
Alaska Native/ American Indian	26%
Black	11%
Asian	2%
Native Hawaiian/ Pacific Islander	<1%
More than one Race	1%
Hispanic Ethnicity	9%
Age Range	
0-12 years	<1%
13-24 years	3%
25-44 years	54%
45+ years	41%
65+ years	2%
Unknown	<1%

PREVALENCE OF HIV INFECTION IN SPECIFIC POPULATIONS

Civilian Applicants for Military Service. All civilian applicants for military service are screened for HIV infection. This includes individuals applying for active duty or reserve military service (including the National Guard), the service academies, and the Reserve Officers Training Corps (ROTC). From October 1985 through December 2003, 24,628 (20,067 male and 4,561 female) individual applicants for military service in Alaska were tested. Of these, 3 (0.01%) had test results showing HIV infection. All three were males, including one aged 20-24 years and two 30 years or older, with one White, one Black, and one of unspecified race.

HIV SCREENING AND HIV PARTNER SERVICES

Although it is likely that a number of individuals with HIV are unaware of their infection, HIV screening of the general population in Alaska has not been particularly effective in identifying previously undiagnosed HIV infections. For example, in 2005, data on HIV tests submitted to the State Virology Laboratory from four public health clinics that offer testing in the context of reproductive health services show that of 3,269 individuals tested, four (0.12%) were HIV-positive. In contrast, partner notification activities, working with persons diagnosed with HIV to confidentially notify their sexual and needle-sharing partners of their exposure, remain the most effective means of reaching persons at highest risk prior to symptomatic disease. In 2005, 46 HIV-positive individuals were interviewed for partners; 82 partners were notified by public health personnel; 67 of these partners accepted HIV counseling and testing, and 8 (12%) were newly diagnosed with HIV. The 8 cases identified through partner services constituted 29% of the 28 cases of HIV newly diagnosed in Alaska in 2005. From 2003-2005, partner notification activities identified 37% of all cases of HIV newly diagnosed in Alaska.

Different models of HIV testing through targeted outreach in community settings frequented by persons at high risk, some using rapid HIV tests, are being explored to identify ways to best reach persons with undiagnosed HIV infection.

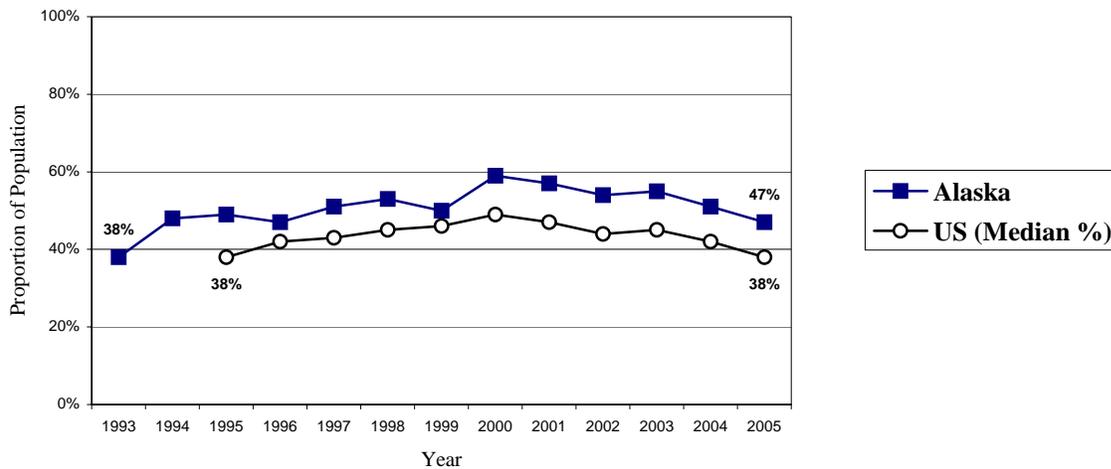
SELF-REPORTED HIV TESTING

The Behavioral Risk Factor Surveillance System (BRFSS) is a national survey developed by CDC to monitor state-level prevalence of the major behavioral risks among adults. The BRFSS has been conducted yearly in Alaska since 1990 by the Alaska Division of Public Health. Health interviews are conducted by phone with adults 18 years and older. Data are statistically weighted to be representative of the state's population.

The BRFSS interview includes several questions about HIV testing experience. Respondents are asked: "Have you ever been test for HIV? Do not count tests you may have had as part of a blood donation." In 2004, 51% of respondents in of Alaska aged 18-64 years had ever had an HIV test aside from testing as part of donating blood. In 2005, 47% of Alaskans reported ever having had an HIV test. As shown in Figure 15, Alaska has consistently been slightly higher than the nation in the percentage of persons who report being tested (State of Alaska 2006).

Respondents are read a list of four HIV transmission risk factors and, without specifying a risk, asked if any applied to them in the past 12 months. Risk factors include: use of intravenous drugs; treatment for STD; exchange of sex for money or drugs; and anal sex without a condom. In 2004 and 2005, 4% of respondents reported having participated in some high-risk activity in the previous 12 months.

Figure 15. Self-reported HIV Testing, Aged 18-64 Years: Alaska vs. Nationwide



HIV TESTING DURING PRENATAL CARE

Antiretroviral therapy is effective in reducing HIV transmission during pregnancy and delivery, and has helped reduce perinatal infection rates in Alaska and nationwide. The majority of pregnant women in Alaska received HIV screening as part of their prenatal care.

Pregnancy Risk Assessment Monitoring Survey (PRAMS). PRAMS is an ongoing national surveillance study conducted by states to collect information on maternal behaviors, attitudes, and experiences. The PRAMS includes a systematic, stratified random sample of mothers who have given birth to live infants. Response data are statistically weighted to represent the state's population of women with live births.

Beginning in 1996, surveyed mothers were asked if their prenatal health care providers had (1) counseled them about HIV prevention and (2) discussed HIV testing with them. National PRAMS data indicate that discussion of HIV testing is highly correlated with the occurrence of testing. The question on counseling was dropped from the survey after 1999.

PRAMS survey results through 2003 (the most recent available PRAMS data) for the HIV-related questions follow.

Table 38. Percent of Women Giving Birth to Live Infants Whose Prenatal Health Care Providers Counselled Them About HIV Prevention, Alaska

	2000	1999	1998	1997	1996
Number of Live Births in Alaska	9,766	9,819	9,793	9,820	8,198
Response					
Yes	(question not asked)	46.8%	46.7%	42.9%	43.9%
No		49.7%	50.3%	54.0%	52.4%
Skipped (no prenatal care)		0.9%	0.8%	1.7%	1.4%
No response		2.6%	2.2%	1.3%	2.3%

Table 39. Percent of Women Giving Birth to Live Infants Whose Prenatal Health Care Providers Discussed HIV Testing With Them, Alaska

	2003	2002	2001	2000	1999
Number of Live Birth in Alaska	9,718	9,612	9,627	9,766	9,819
Response					
Yes	79.9%	82.3%	78.8%	80.9%	76.1%
No	17.3%	15.4%	18.4%	16.8%	19.9%
Skipped (no prenatal care)	1.5%	0.6%	1.0%	0.6%	0.9%
No response	1.3%	1.8%	1.8%	1.8%	3.1%

Alaska currently has a low incidence of perinatal HIV transmission. PRAMS data show a relatively large and consistent proportion of those women with live births reported discussion of (and likely testing for) HIV during pregnancy. The number of HIV-infected women of childbearing age is relatively small but will continue to grow as additional women become infected with HIV and infected persons live longer, healthier lives. Of the 202 cases of HIV/AIDS reported in females in Alaska, 157 were not known to have died as of December 31, 2005. Of these, 129 women were between the ages of 15-44 years as of December 31, 2005 and theoretically of childbearing age. It will be increasingly important to provide individualized services to HIV-positive women, including services related to their reproductive health and the health of their children, to increase the number of pregnant women receiving prenatal care, and to progress toward universal, voluntary HIV testing as a routine part of prenatal care.

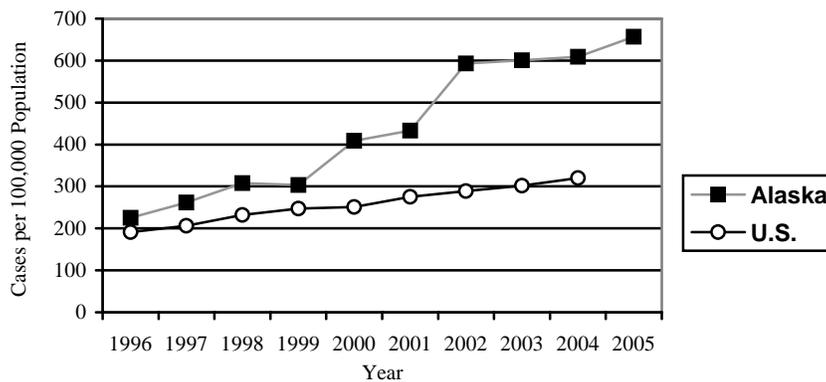
INDICATORS OF POTENTIAL RISK FOR HIV

Reportable Sexually Transmitted Diseases (STD). The most common reportable sexually transmitted infections in Alaska and the rest of the U.S. are chlamydia, gonorrhea, and syphilis, in decreasing order of prevalence. Chlamydia infection is most common in adolescents and younger adults, especially females, in Alaska. Gonorrhea infection is less common than chlamydia, and most cases occur in young adults. Syphilis is relatively uncommon and most recent cases occurred in males. STD are indicators of unprotected sex.

A relatively small number of individuals with chlamydia were ever reported with gonorrhea, indicating that these infections are associated not only with unprotected sex but also with participation in fairly distinct sexual networks. It was uncommon for persons with chlamydia and/or gonorrhea to have been reported with HIV infection, but a relatively high proportion of recent cases of infectious syphilis in Alaska were in persons who had or had been recently exposed to HIV infection.

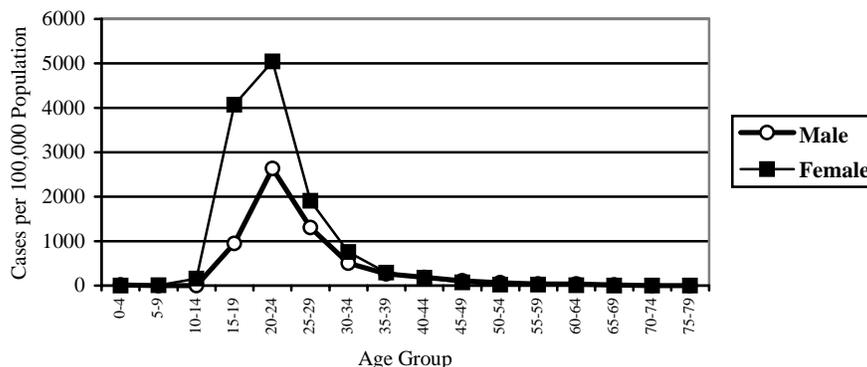
Chlamydia in Alaska. Chlamydia rates have been high in Alaska since the infection was first made reportable in 1996. Rates of chlamydia infection have continued to increase in Alaska and the U.S., and Alaska rates have ranked among the highest in the U.S. in recent years. While the increase in cases reported in Alaska may, in part, represent a true increase in disease incidence, other likely contributors include recent improvements in disease detection due to the use of more sensitive laboratory technology and non-invasive (urine) specimen collection methods, as well as increased testing of exposed partners and more screening of populations at risk of infection.

Figure 16. Chlamydia Rates in Alaska and the United States, 1996-2005



A total of 4,357 cases of chlamydia were reported in Alaska in 2005, a rate of 657 cases per 100,000 population. Case numbers in 2005 increased 9% over 2004 and represented the largest annual increase since 2002. There were 2,910 (67%) cases reported in females and 1,447 (33%) in males. Of the 2,910 cases in females, 51 (2%) were associated with pelvic inflammatory disease.

Figure 17. 2005 Chlamydia Rates in Alaska by Sex and Age Group (N=4,357)

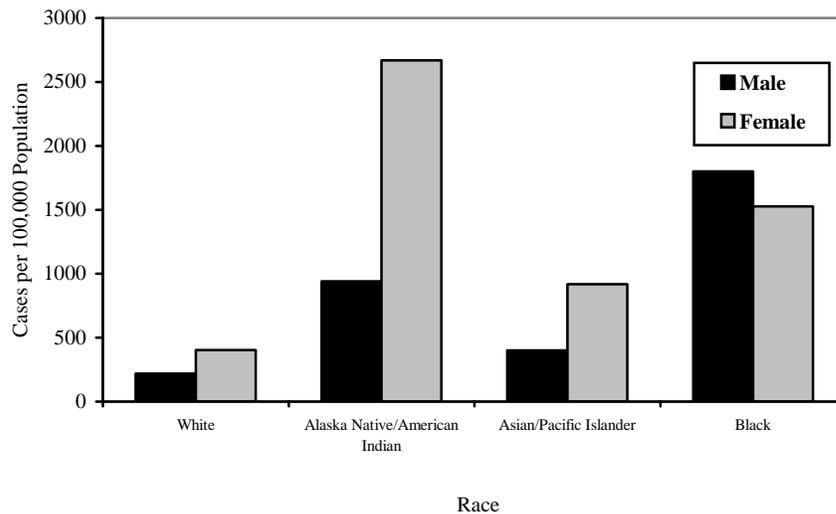


Highest 2005 chlamydia case rates in females were among those aged 20-24 years (5,046 per 100,000 females) and 15-19 years (4,075 per 100,000 females). Highest 2005 chlamydia case rates in males were among those aged 20-24 years (2,633 cases per 100,000 males).

Chlamydia case rates among males were highest in Blacks (1,800 per 100,000 males) and Alaska Natives/American Indians (940 per 100,000 males). Case rates among females were highest in Alaska Natives/American Indians (2,669 per 100,000 females) and Blacks (1,526 per 100,000 females).

Figure 18. 2005 Chlamydia Rates in Alaska by Race and Gender (N=4,357)

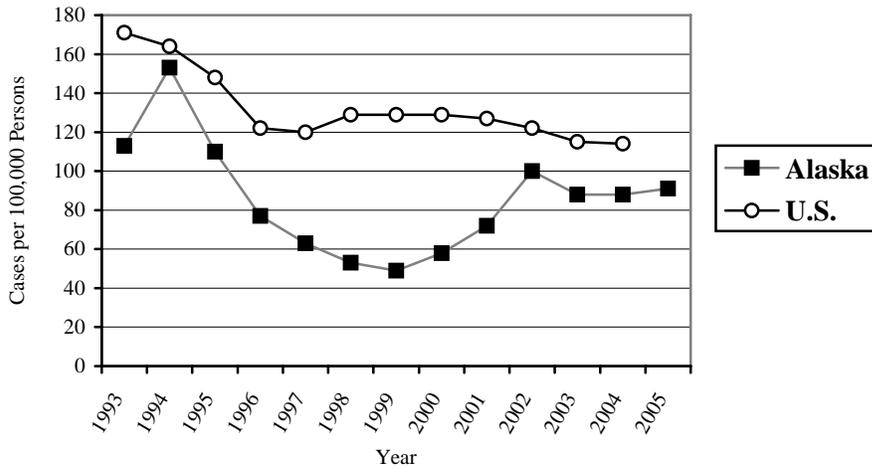
(34 males and 46 females of unknown race are not included in the graph)



HIV and Chlamydia. Cases of chlamydia reported in Alaska from 1/4/96 through 5/17/06 (29,251 cases) were matched against all cases of HIV infection reported in Alaska through 5/15/06 (1,084 cases). Of all individuals ever reported with HIV, 19 individuals (9 females, 10 males) were diagnosed with a chlamydia infection before or at the time of HIV diagnosis, and 19 individuals (11 females, 8 males) had one or more chlamydia diagnoses after HIV was diagnosed.

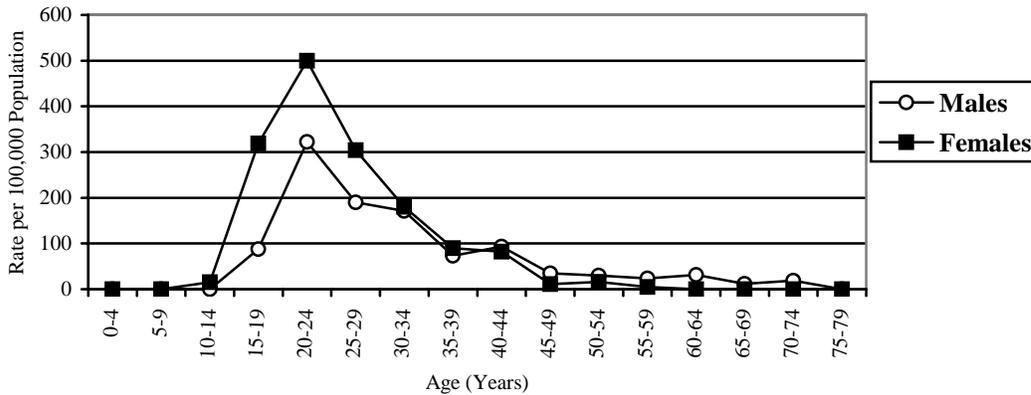
Gonorrhea in Alaska. Gonorrhea rates have declined considerably in Alaska since the historic highs recorded in the 1970's during construction of the TransAlaska oil pipeline. Although they remain below U.S. rates, Alaska gonorrhea rates have increased in recent years. While this likely represents a true increase in disease incidence, other likely contributors include recent improvements in disease detection due to the use of more sensitive laboratory technology and non-invasive (urine) specimen collection methods, as well as increased testing of exposed partners and increased screening of populations at greater risk of infection.

Figure 19. Gonorrhea Rates in Alaska and the United States, 1993-2005



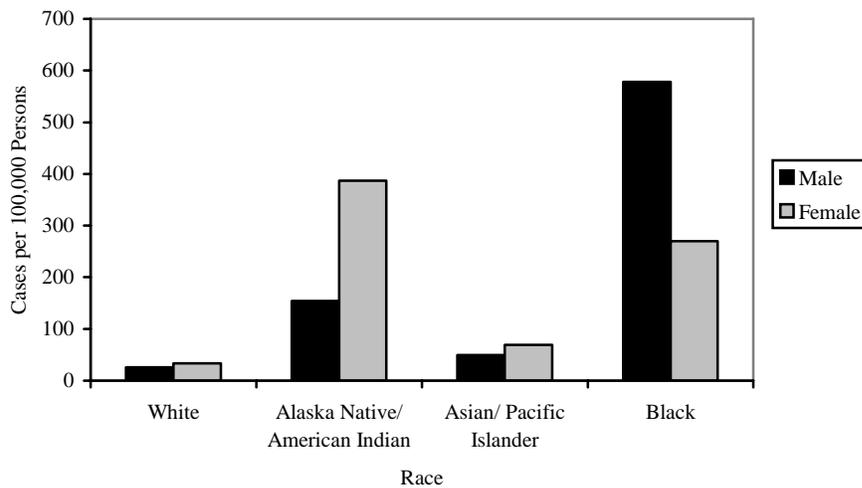
A total of 601 cases of gonorrhea were reported in Alaska in 2005 (91 cases per 100,000 persons). This represents a 4% increase over the number of gonorrhea cases in 2004. Of the 601 cases, 349 (58%) cases were in females and 252 (42%) cases in males. Of the 349 cases in females, 17 (5%) were associated with pelvic inflammatory disease. Highest 2005 gonorrhea case rates in females were among those aged 20-24 years (500 per 100,000 females), 15-19 years (319 per 100,000 females), and 25-29 years (304 per 100,000 females). The highest 2005 gonorrhea rate in males was among those aged 20-24 years (322 per 100,000 males).

Figure 20. 2005 Gonorrhea Rates in Alaska by Sex and Age (N=601)



Gonorrhea case rates among males were highest in Blacks (578 cases per 100,000 males) and Alaska Natives/American Indians (154 cases per 100,000 males). Case rates among females were highest in Alaska Natives/American Indians (387 cases per 100,000 females) and Blacks (269 cases per 100,000 females).

Figure 21. 2005 Gonorrhea Rates in Alaska by Race and Gender (N=601)
(9 male cases of unknown race are not included in the graph)



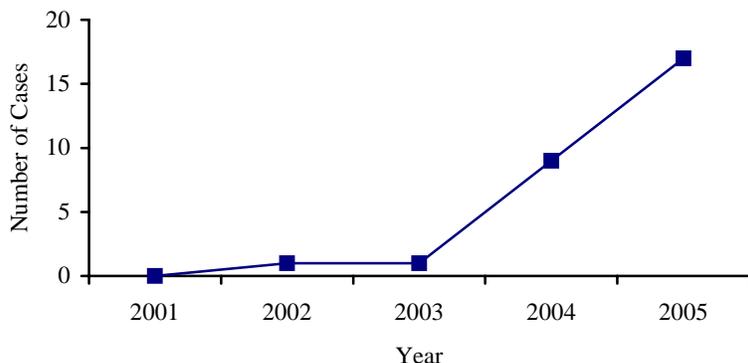
HIV and Gonorrhea. Cases of gonorrhea reported in Alaska from 2/1/72 through 5/17/06 (68,196 cases) were matched against all cases of HIV infection reported in Alaska through 5/15/06 (1,084 cases). Of all individuals ever reported with HIV, 103 individuals (34 females, 69 males) were diagnosed with a gonorrhea infection before or at the time of HIV diagnosis, and 14 individuals (2 females, 12 males) had one or more gonorrhea diagnoses after HIV was diagnosed.

Syphilis in Alaska. Infectious syphilis was not a significant problem in Alaska for many years. An outbreak, largely confined to areas on the road system from Anchorage to Fairbanks, began in late 2004 and was still ongoing at the end of 2005. A total of 26 cases of early syphilis (primary, secondary, and early latent stages) were reported between 9/1/04 and 12/31/05. Of the 26 cases, 22 (85%) were in males and 4 (15%) in females; 13 were in men who acknowledged same sex partners, 12 individuals had risks associated with methamphetamine use, and a number of cases involved anonymous sex associated with use of the Internet. Of the 26 cases, 19 were in Whites, 4 in Alaska Natives/American Indians, and 3 in Blacks.

HIV and Syphilis. All cases of syphilis reported in Alaska from 1/1/73 through 5/17/06 (1,054 cases) were matched against all cases of HIV infection reported in Alaska through 5/15/06 (1,084 cases). Of all individuals ever reported with HIV, 10 individuals (1 female, 9 males) had a syphilis diagnosis before or at the time of HIV diagnosis, and 5 individuals (1 female, 4 males) had a syphilis diagnosis after HIV was diagnosed.

Additionally, of the 26 cases of early syphilis (primary, secondary, and early latent stages) reported between 9/1/04 and 12/31/05, 7 (30%) were in individuals who either had HIV or had recently been named as a sex or needle sharing partner of a person with HIV infection.

Figure 22. Cases of Primary, Secondary, & Early Latent Syphilis, Alaska, 2001-2005



Selected Other Conditions and HIV in Alaska

Hepatitis C. Cases of hepatitis C reported in Alaska from 12/18/89 through 5/17/06 (8,946 cases) were matched against all cases of HIV infection reported in Alaska through 5/15/06 (1,084 cases). Of all individuals reported with HIV, a total of 117 (34 females, 83 males) were ever reported with hepatitis C (11% of all HIV cases). Of these 117 individuals, 18 were diagnosed with hepatitis C diagnosis before or at the time of HIV diagnosis, and 99 were diagnosed with hepatitis C after HIV was diagnosed.

Hepatitis B. Cases of hepatitis B reported in Alaska from 2/1/73 through 5/17/06 were matched against all cases of HIV infection ever reported in Alaska through 5/15/06 (1,084 cases). Of all persons reported with HIV, a total of 8 (2 females, 6 males) were ever reported with hepatitis B, and none were reported after 1992.

Hepatitis A. Cases of hepatitis A reported in Alaska from 1/1/72 through 5/17/06 were matched against all cases of HIV infection reported in Alaska through 5/15/06 (1,084 cases). Of all persons reported with HIV, a total of 7 (3 females, 4 males) were ever reported with hepatitis A.

Tuberculosis. Cases of tuberculosis (TB) reported in Alaska from 1/1/72 through 5/17/06 were matched against all cases of HIV infection reported in Alaska through 5/15/06 (1,084 cases). Of all persons reported with HIV, a total of 20 (3 females, 17 males) were ever reported with TB. Of these, 5 cases had TB disease diagnosed before, 2 at the time of, and 13 after diagnosis with HIV.

Appendix B

Factors and Weighting for Preliminary Prioritizing Based on HIV and STD Data



2007-2009 Alaska HIV Prevention Plan

Appendix B: Factors and Weighting for Preliminary Prioritizing Based on HIV and STD Data

Target Populations by Risk Factor ; HIV/AIDS cases through 2005 Adult and Adolescents ≥ 15 year old						
Target Pop by Surveillance Category	Factor	Data	Scale	Rating	Weight	Score
	HIV/AIDS 2005 Prevalence #		1: 0 – 49 2: 50 – 99 3: 100 – 199 4: 200 – 299 5: 300 - 399		3	
	HIV 5 year Incidence #		1: 0 – 9 2: 10 – 19 3: 20 – 29 4: 30 – 39 5: 40 - ≥ 50		3	
	Relative Risk of Primary Risk Behavior		1: Heterosexual contact with person of unknown status and risk 2: Heterosexual contact with HIV positive or high risk partner 3: male with male sexual contact 4: Injection drug use 5: male with male sexual contact and injection drug use		1	
					Total Score	

Target Populations by Demographics ; HIV/AIDS cases through 2005 Adult and Adolescents ≥ 15 year old; GC and CT cases in 2005 all ages.						
Target Pop	Factor	Data	Scale	Rating	Weight	Score
	HIV/AIDS 2005 Prevalence #		1: 0 – 49 2: 50 – 99 3: 100 – 199 4: 200 – 299 5: 300 - 399		3	
	HIV/AIDS 2005 Prev. Rate/100,000		1: 0 – 99/100,000 2: 100 - 199/100,000 3: 200 – 299/100,000 4: 300 – 399/100,000 5: 400 - ≥ 499 /100,000		3	
	HIV 5 year Incidence #		1: 1 – 9 2: 10 – 19 3: 20 – 29 4: 30 – 39 5: 40 - ≥ 50		3	
	HIV Incidence Rate/100,000 5 yr average		1: 0 – 4/100,000 2: 5 – 9/100,000 3: 10 – 14/100,000 4: 15 – 19/100,000 5: 20 - ≥ 25 /100,000		3	
	Gonorrhea (GC) 2005 Case Rate/100,000		1: 0 - 99/100,000 2: 100 – 199/100,000 3: 200 – 299/100,000 4: 300 – 399/100,000 5: 400 - ≥ 499 /100,000		1	
	Chlamydia (CT) 2005 Case Rate/100,000		1: 0 - 499/100,000 2: 500 - 999/100,000 3: 1,000 – 1,999/100,000 4: 2,000 – 2,999/100,000 5: 3,000 – 3,999/100,000		0.5	
					Total Score	

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