2024 North Dakota HIV, STI, TB, & Viral Hepatitis Epidemiologic Profile

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Introduction

The HIV, STI, TB, and Viral Hepatitis Epidemiologic Profile describes the epidemiology of HIV/AIDS, sexually transmitted infections (chlamydia, gonorrhea, and syphilis), tuberculosis (latent and active), hepatitis B (HBV), and hepatitis C (HCV) in North Dakota during 2024. This

profile covers the general epidemiology of the above conditions in terms of sex, age, race, geography and associated casual factors. This profile was created to assist in developing a Comprehensive Jurisdictional HIV and Viral Hepatitis Prevention and Care Plan. Information in this report is used to characterize and predict the changing epidemic at the local level. North Dakota data is summarized annually to help the North Dakota Department of Health and Human Services (NDHHS) answer questions about how to prevent these diseases in the population.

Table 1. Common abbreviations/acronyms used throughout this profile

ABBREVIATION	FULL DESCRIPTION
ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CDC	Centers for Disease Control & Prevention
CSTE	Council of State and Territorial Epidemiologists
CTR	Counseling, Testing, and Referral
EHARS	Electronic HIV/AIDS Reporting System
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDU	Injection Drug Use
HRSA	Human Resources and Services Administration
MSM	Men Who Have Sex with Men
NDHHS	North Dakota Department of Health and Human Services
PLWH	Persons Living With HIV/AIDS
PrEP	Pre-exposure prophylaxis
PWID	Persons Who Inject Drugs
RW	Ryan White
STI	Sexually Transmitted Infection
TB	Tuberculosis

Data Sources

Data was compiled from several sources to present the most complete picture of the epidemiology of diseases as possible. However, because few behavioral or supplemental surveillance projects are available in North Dakota, core surveillance data is utilized extensively. Each data source has strengths and limitations. A brief description of each source follows.

Maven

The North Dakota Electronic Disease Surveillance System, known as Maven, is a system that allows public health officials to receive, manage, process, and analyze disease and other

condition-related data. Maven offers tools for automatic disease reporting, case investigations, and case follow-up and management within the state of North Dakota. It is an integrative system allowing easy sharing and connecting among the NDHHS, local public health, and providers.

HIV/AIDS Data Sources

HIV/AIDS CASE SURVEILLANCE

A diagnosis of HIV/AIDS is a mandatory reportable condition to the NDHHS according to North Dakota Century Code Chapter 23-07-01 and North Dakota Administrative Code Chapter 33-06-01. Reports of HIV/AIDS cases can be provided by physicians, hospitals, laboratories, and other institutions. The data is stored in the electronic HIV/AIDS Reporting System (eHARS) and Maven databases. Statistics and trends presented in this report were derived from HIV/AIDS case data reported to the NDHHS cumulatively starting in 1984 through December 31, 2024.

HIV/HCV COUNSELING AND TESTING DATA

The NDHHS contracted with 21 Counseling, Testing and Referral (CTR) sites in 2024. CTR sites offer free, confidential HIV and HCV rapid and confirmatory testing and counseling in North Dakota. Participants complete risk assessments as part of their visit. These risk assessments along with demographics, testing history, test results and sexual health history information are reported to the NDHHS via Maven.

HIV CARE DATA/RYAN WHITE PART B PROGRAM

The North Dakota Ryan White Part B Program assists low-income North Dakota residents living with HIV to access health and supportive services. The program was implemented in 1991. To be eligible for the North Dakota Ryan White Program Part B, a person must be a resident of North Dakota, have HIV, and have an income level at 500 percent or lower than the federal poverty level. Program contracts with 14 local public health agencies, one clinic, two community action agencies, and one AIDS service organization to provide case management and services to people living with HIV in ND.

The Ryan White Part B Program manages program information such as client eligibility and service utilization data using Maven surveillance system. This has allowed for integration and sharing of information between HIV Prevention and Surveillance programs. This ensures that required client-level data elements are collected and reported to HRSA. The “real time” nature of the networked system allows the Ryan White Part B Program to monitor specific indicators (e.g., number of clients without medical insurance) in a timely fashion, and it gives case managers access to view lab work and medication so that clients can be served more efficiently.

STI Data Sources

STI SURVEILLANCE CASE REPORTING

The NDHHS STI Program conducts statewide surveillance to determine the number of reported cases of STIs. The data is used to monitor trends and to offer voluntary partner counseling and

partner notification services. Chlamydia, gonorrhea, and syphilis cases are mandatory reportable conditions in North Dakota. STI surveillance data can serve as surrogate markers for unsafe sexual practices and may demonstrate changes in behavior among specific populations that increase their risk for HIV infection. Because of a shorter time from infection to symptomatic disease, STI diagnoses may better indicate recent unsafe behavior and/or changes in community norms. In addition, certain STIs can facilitate the transmission of HIV infection.

Tuberculosis Surveillance Data

Tuberculosis (*Mycobacterium tuberculosis* and *Mycobacterium bovis*) disease and tuberculosis infection are mandatory reportable conditions and must be reported to the NDHHS according to North Dakota Administrative Code Chapter 33-06. The data are stored within Maven and are used to monitor ongoing treatment and management of tuberculosis disease and tuberculosis infection. The Maven system also serves as a method of communication between the TB Prevention and Control program and the TB contract pharmacy to ensure timely medication dispensing.

Viral Hepatitis Surveillance Data

The Hepatitis Program receives reports of acute and chronic cases of HBV and HCV infections. HBV infections are investigated to determine if post-exposure immune-prophylaxis procedures for contacts were followed

Cases of HCV that are reported as acute are followed by a case investigation. Cases of HCV that are determined to be chronic HCV are routinely investigated. There is no partner notification conducted by the NDHHS. Under-reporting of both acute and chronic HCV infections in North Dakota is likely. Data reported here has begun to distinguish between resolved and active infections.

Vital Statistics Data

BIRTH AND DEATH DATA

The NDHHS Division of Vital Statistics collects information on all births and deaths in North Dakota. The birth certificate form includes demographic information on the newborn infant and the parents, prenatal care, maternal medical history, mode of delivery, events of labor and abnormal conditions of the infant.

Death certificates include demographics, underlying cause of death and factors contributing to the death. The surveillance program reviews death certificates on a weekly basis to ascertain deaths of HIV-positive persons. The surveillance program also electronically matches data with death and birth databases annually to ascertain deaths of persons with HIV/AIDS and births to HIV-infected females.

Demographic Data

U.S. CENSUS BUREAU

The U.S. Census Bureau collects and provides timely information about the people and economy of the United States. The U.S. Census Bureau website (http://www.census.gov) includes data on demographic characteristics (e.g., age, race, ethnicity and sex) of the population, family structure, educational and income level, housing status and the proportion of persons who live at or below the poverty line. Summaries of the most requested information for states and counties are provided, as well as analytical reports on population changes, age, race, family structure and apportionment. State and county-specific data are easily accessible, and links to other web sites with census information are included. For this report, 2024 population estimates are used unless otherwise noted.

Guidelines to Interpretation of the Data

Decisions about how to allocate limited resources for prevention and care services depend, in part, on appropriate interpretation of epidemiological data. The following guidelines are intended to facilitate proper interpretation of the tables and figures presented in this profile.

The data has certain limitations. This report will not specifically differentiate, unless indicated, whether an individual is or is not at the stage of AIDS for HIV infections. The first AIDS case reported in North Dakota was diagnosed in 1984. Reporting of HIV-infected persons in North Dakota began in 1984. HIV surveillance reports may not be representative of all infected persons, because not all infected persons have been tested or reported. Data is collected for the entire state of North Dakota, which includes data for patients who are diagnosed for the first time in North Dakota, as well as patients who move to North Dakota after they have been diagnosed. Data does not necessarily consider emigration out of North Dakota, although efforts are made to account for this in HIV prevalence data. State and county of diagnosis do not change even if a person moves to a different county or out of state.

The data presented in this profile only includes cases that met the current case definition documented by CSTE and CDC. This report does not include cases that have not been diagnosed by laboratory methods or by a health care provider.

Rates have been calculated for 12-month periods per 100,000 persons. The denominator for calculating rates, unless otherwise noted, is based on 2024 population estimates from the U.S. Census Bureau. The numerator is the number of cases reported during the 12-month period. This number is divided by the population estimate and multiplied by 100,000. For example, race-specific rates are the number of cases reported for a racial/ethnic group during the preceding 12-month period divided by the estimated population for that race/ethnicity and multiplied by 100,000. Those categorized as white are white, alone. Hispanic ethnicity can be of any race. If a race is not included in a graph, it is due to small numbers.

The data presented in this report are current as of time of publication. However, the data may be variable as new information is received and may differ from other reports.

North Dakota Demographics

Click here to see the dashboard, demographics are section I.

North Dakota is a rural state that covers 70,704 square miles, and in 2024, had an estimated population of 796,568, according to the U.S. Census Bureau. North Dakota ranks 47th in the nation by population. It contains 53 incorporated counties and 357 cities. 9 cities have populations of more than 10,000 and 20 cities have populations of more than 2,500. County populations in North Dakota range from 660 to 200,945 people. The six counties along the eastern border with Minnesota account for more than one-third of the state's population.

Race Distribution

Some conditions are also broken down by country of birth but not all. It is a priority of the division to continue and improve collection of country of birth data to better understand racial disparities.

Social Characteristics

The social characteristics estimates of North Dakota include education, place of birth and poverty level. The majority (94.1%) of the population age 25 and older have graduated from high school. The percentage of the population born in a country other than the United States is 5.3%. Roughly eleven percent (11.1%) of the North Dakota population live on wages below the federal poverty level. For a household of one, that equates to $15,060 in 2024.

Human Immunodeficiency Virus (HIV)

HIV/AIDS INCIDENCE AND PREVALENCE

Click here to see the dashboard, HIV is section II.

Incidence refers to cases newly diagnosed within the state during a given year. Persons diagnosed in another state, who then move to North Dakota, are not counted in an incidence report. North Dakota reported 38 new cases of HIV/AIDS in 2024.

Prevalence refers to all cases of HIV/AIDS actively living in North Dakota as of December 31, 2024. In 2024, there were 671 people with HIV/AIDS living in North Dakota.

Perinatal Exposures

Perinatal HIV is the transmission of HIV from mother to child. Treatment of the mother during pregnancy and treatment of the infant after birth can minimize the risk of HIV transmission. The NDHHS follows up regarding the pregnancy status of all females of child-bearing age (14 to 49

years) who are HIV positive. During 2024, there were 3 infants born to mothers who are HIV positive, and HIV transmission to the infant was prevented in each instance.

HIV Services – Ryan White Program Part B

Click here to see the dashboard, Ryan White and HIV care continuum are section III.

The North Dakota Ryan White Program Part B is federally funded through the Health Resources and Services Administration (HRSA) and administered by the North Dakota Department of Health and Human Services (NDHHS) Sexually Transmitted and Bloodborne Diseases Unit.
To qualify for the program, an individual must:

- Be living with HIV
- Be a resident of North Dakota
- Have a gross household income at or below 500% of the Federal Poverty Level (2024: $75,300 for a household of one)

Ryan White Part B funds case management and core medical services that connect individuals to medical care and treatment. It also supports services that help clients stabilize their living situations, remain engaged in care, and maintain overall well-being.

Housing Status

Access to affordable and stable housing is essential for maintaining engagement in medical care and treatment. Individuals who experience housing instability are at greater risk of falling out of care and experiencing treatment interruptions, which can lead to treatment resistance, poorer health outcomes, and higher healthcare costs.

The program assists clients through emergency financial assistance for rent and utilities and reimburses housing case management services.

Insurance Status

Health coverage is critical for individuals living with HIV to afford ongoing medical care and treatment. While the Ryan White Program is not health insurance, it serves as a safety net by:

- Covering HIV-related medical care and medication costs for uninsured clients
- Assisting clients with enrollment in eligible health coverage
- Supplementing (or wrapping around) public and private insurance by covering deductibles, copayments, and select premiums

Because clients may experience gaps or changes in insurance coverage, Ryan White agencies collaborate closely with Marketplace enrollment assisters to help clients identify and enroll in eligible private insurance plans. Clients may also qualify for premium assistance for approved Marketplace plans after tax credits have been applied.

As a payer of last resort, the Ryan White Program reimburses services only when no other payer is available. Clients eligible for Medicaid, Medicare, and private insurance must first pursue those options. The Ryan White Program then helps cover remaining HIV-related medical costs.

Ryan White Part B Services

Core medical services reimbursed through Ryan White Part B include:

- Outpatient/ambulatory HIV medical care
- Oral health care
- Outpatient mental health services
- Outpatient substance use treatment
- Medical case management
- Medication and insurance premium assistance (through the AIDS Drug Assistance Program [ADAP])

Support services include:

- Non-medical case management
- Emergency financial assistance (rent and utilities)
- Medical transportation
- Group and individual psychosocial support
- Nutritional supplements

ADAP (AIDS Drug Assistance Program)

The North Dakota ADAP provides medication assistance to uninsured clients and insurance assistance to clients with health coverage. Insurance assistance may include payment of medication copays and insurance premiums for private insurance, Medicare Part D, Part C (Medicare Advantage), and Medicare Supplemental plans.

ND ADAP maintains an open formulary aligned with the North Dakota Medicaid formulary and reimbursement rates, excluding certain medication categories. The formulary is structured in three tiers:

- Tier I: HIV-related antiretroviral medications
- Tier II: Antiviral, antifungal, and antibacterial medications for opportunistic and related infections
- Tier III: Medications for comorbid conditions (e.g., diabetes, cardiovascular disease)

In 2022, Cabenuva, a monthly or bi-monthly injectable medication, was added to the ADAP formulary for insured clients. Exceptions may be made to provide coverage for uninsured clients while their coverage is being established.

HIV Care Continuum

The HIV care continuum is a model that outlines the steps of HIV medical care from the initial diagnosis to achieving the goal of viral suppression and it indicates the proportion of individuals living with HIV who are engaged at each stage. The continuum has the following stages: diagnosis of HIV infection, linkage to care, retention in care, receipt of antiretroviral therapy and achievement of viral suppression. As various obstacles contribute to low engagement in HIV care and limit the effectiveness of efforts to improve health outcomes, the care continuum is used to identify gaps in HIV services and develop strategies to enhance engagement in care and outcomes for PLWH.

The CDC currently uses two different continuums. The HIV prevalence-based continuum shows steps of the continuum as a percentage of the total number, or the prevalence, of PLWH (persons who know and the estimated number of people who do not know their HIV status). The diagnosis-based continuum shows steps as a percentage of the number of PLWH who have been diagnosed. As a low-incidence state, North Dakota has adopted the diagnosis-based continuum.

The continuum steps below are for PLWH in North Dakota as of December 31, 2024. The measurement year is the calendar year 2024.

- HIV-diagnosed: number of prevalent HIV cases; prevalent cases include the number of newly diagnosed HIV cases in North Dakota, as well as previously diagnosed HIV cases who moved to the state and were living in North Dakota as of December 31, 2024
- Linked to care: the number of PLWH in the calendar year 2024 who had one or more viral load or CD4 tests after their diagnosis date
- Retained in care: the number of PLWH with one or more viral load or CD4 lab tests in 2024
- Antiretroviral use: number of PLWH who have a documented antiretroviral therapy (ART) prescription in the Maven surveillance system in 2024
- Viral load suppression: number of PLWH whose most recent HIV viral loads in 2024 were less than 200 copies/milliliter (mL).

Limitations: HIV is a reportable condition in North Dakota, and all viral load and CD4 lab tests are electronically reported to the NDHHS. However, the NDHHS does not perform medical chart reviews on PLWH to determine all HIV-related medical visits or antiretroviral use. The lack of review contributes to the possible underreporting of the number of individuals linked and retained in care and underreporting of individuals receiving ART. The number of individuals prescribed ART is determined by using Ryan White ADAP reimbursed claims data. Therefore, only individuals on RW and whose medications are reimbursed through ADAP or those that are virally suppressed are reported as receiving ART. This excludes individuals not on RW and those

on RW but whose medications are reimbursed through primary coverage (i.e., private insurance, Medicaid or Medicare).

Reaching viral load suppression is essential for several reasons. Viral suppression ensures that the health of the person is maintained or restored. It also minimizes or eliminates short- or long-term damage caused by the virus, and it lowers the risk of HIV transmission since there is a lower amount of virus in the blood and body fluids.

The HIV Care Continuum provides a model to monitor progress toward the ND Integrated HIV and Viral Hepatitis Prevention and Care Plan's objectives that follow the National HIV/AIDS Strategy. The NDHHS continues to identify appropriate interventions to address the racial and socio-economic disparities and determine necessary re-engagement activities to improve outcomes at each stage of the care continuum. The NDHHS will reevaluate the existing services, such as partner services, additional testing for comorbidities, educational opportunities regarding care and treatment and prevention with positives activities to assess their effectiveness and potential improvement areas.

HIV and HCV Counseling, Testing and Referral Program

Click here to see the dashboard, HIV CTR is section IV and HCV CTR is section V.

The Counseling, Testing and Referral (CTR) Program offers HIV and HCV testing. Additionally, CTR cites provide HAV and HBV vaccinations to those at risk for HCV. This program aims to increase the accessibility of HIV and HCV health care services for populations at risk. CTR sites seek to inform clients of their HIV and HCV status, counsel and support risk reduction and secure needed referrals (i.e., medical, social, prevention and partner services).

The NDHHS contracted with 20 free and confidential CTR sites in 2024. With contracted sites, their satellite clinics and non-contracted partners, 36 facilities across North Dakota are offering CTR services. Please note in the map of CTR locations, some cities have multiple CTR sites; thus, the number of dots does not equate to the total number of sites offering CTR services. Contracted CTR sites consist of eight family planning clinics, six local public health units, three student health centers, two pregnancy/sexual health clinics, and one clinic that specializes in LGTBQ+ healthcare. Six family planning clinics and local public health units also offer services at their county correctional facilities. CTR sites often have the advantages of providing comprehensive health care, including STI testing and treatment, additional vaccinations, primary health care, substance abuse referrals and many other services, and integrated HIV and HCV testing.

Viral Hepatitis

Hepatitis is the general term that means "inflammation of the liver." Many factors can cause hepatitis, including toxins, drugs, viruses, parasites and other factors. There are several types of viral hepatitis, but hepatitis A (HAV), hepatitis B (HBV) and hepatitis C (HCV) are the most common types of viral hepatitis in the U.S. and North Dakota. HAV is transmitted via fecal-oral route. Only HBV and HCV will be discussed in this document.

Hepatitis B Virus (HBV)

Click here to see the dashboard, HBV is section VI.

In 2024, 72 cases of HBV were reported in North Dakota as meeting the CDC case definition. Reported numbers include both confirmed and probable cases.

Acute HBV

1 of the 72 cases were acute, meaning they were recently infected within the past six months. The rest of the cases were chronic but being reported for the first time.

Perinatal Follow-Up

The North Dakota Perinatal Hepatitis B Prevention Program seeks to prevent perinatal hepatitis B infections by managing infants born to hepatitis B positive women. Case management includes contacting hepatitis B positive women before delivery to educate them regarding hepatitis B virus transmission and the importance of hepatitis B immune globulin (HBIG) and hepatitis B vaccine for their infant. The perinatal hepatitis B coordinator then notifies the hospital where the woman is planning to deliver so they are prepared to administer HBIG and hepatitis B vaccine to the infant at birth.

After delivery, the perinatal hepatitis B coordinator works with the infant's health care provider to ensure that all three doses of vaccine are given and that hepatitis B serology testing is performed at nine months of age, 1-2 months after the last dose of vaccine. Hepatitis B serology testing is essential to determine if the infant gained protection from the vaccine and ensure they did not develop hepatitis B infection.

Hepatitis C Virus (HCV)

Click here to see the dashboard, HCV is section VII.

In 2024, North Dakota received 348 reports of persons newly identified via positive laboratory results that indicate past or present HCV infection. Of these 348 cases, 15 were identified as acute HCV, 40 were probable chronic, and 290 cases were confirmed chronic.

Acute HCV

Of the 15 acute HCV, 10 cases were reported as female and 5 as male. Regarding race, 9 cases reported as American Indian/Alaska Native, 4 reported White, and 1 as Native Hawaiian, Pacific Islander. Regarding risk, 5 of the cases reported incarceration as a risk factor, 9 reported to have ever injected drugs. One 2024 Acute HCV (71 year old) case was due to a lung transplant performed in Minneapolis, the patient passed away by the end of MBY 2024 to respiratory failure. The average age of 2024 acute HCV cases in ND was 35.5 years with 31 years as the median. Finally, Burleigh County had the highest case count at 5 acute HCV cases in 2024.

Perinatal HCV

Of the 348 new 2024 reported cases, 3 were Perinatal per the CDC 2018 Case Definition.

Coinfections with HCV

3% of chlamydia, 13% of gonorrhea cases had active HCV infections, and 24.6% syphilis infections had active HCV infections in 2024. Of the 92 syphilis/HCV coinfections 47 were women (3 pregnant), 63 were American Indian/Alaska Native, and the average age of cases was 35. Regarding risk, 44 cases reported injection drug use (IDU) and 40 had ever been incarcerated. The majority of cases were found in Burleigh (32) and Sioux (21) counties.

Social Vulnerability Index and Syringe Service

Social Vulnerability refers to demographic and socioeconomic factors that adversely impact communities that encounter health risks or community stressors. A Social Vulnerability Index (SVI) refers to a data informed tool to identify communities vulnerable to health risks such as disease outbreaks and/or fatalities.

Click here to see the Social Vulnerability Index.

Syringe Service programs (SSPs) are community-based prevention programs that can provide a range of services. SSPs are a harm reduction intervention that have been scientifically proven to reduce the transmission of bloodborne pathogens in persons who inject drugs (PWID)

Click here to see information on ND's Syringe Service Programs.

Sexually Transmitted Infections (STIs)

Syphilis

Click here to see the dashboard, syphilis is section VIII.

Congenital Syphilis

In 2024, there were two congenital syphilis cases reported. Congenital syphilis is acquired by a fetus before birth due to mom not being diagnosed and/or not treated appropriately. In 2018, due to the increase of syphilis cases among woman of childbearing age, the NDHHS recommended pregnant women be tested three times throughout pregnancy for syphilis, at first prenatal visit, 28-32 weeks and at the time of delivery. Both cases in 2024 were due to lack of prenatal care. The infants were appropriately treated for their infections.

Comorbidity Testing

Of the 373 syphilis cases, 265 (71%) had a documented HIV test.

Gonorrhea

Click here to see the dashboard, gonorrhea is section IX.

Treatment, Partner Services and Comorbidity Testing

Of the 819 cases of gonorrhea reported in 2024, 729 (89%) were appropriately treated for their infection. The untreated cases were either due to inappropriate treatment (incorrect antibiotic, dosing etc.) and/or lost to follow-up. Anyone who tests positive for an STI, should also be tested for HIV. Only 275 (34%) of the 819 cases had a documented HIV test.

Chlamydia

Click here to see the dashboard, chlamydia is section X.

Tuberculosis

Tuberculosis Infection

Click here to see the dashboard, tuberculosis is section XI.

People can be infected with the bacteria that causes tuberculosis without causing disease. This is called latent TB infection. For most people who breathe in TB bacteria and become infected, the body can contain the bacteria and prevent it from spreading.

Many people who have TB infection never develop TB disease. In these individuals, the TB bacteria remain inactive for a lifetime without causing disease. However, in others, especially those with a weak immune system or those who have a change in their health, the bacteria become activated, multiply, and cause TB disease. The identification and treatment of TB

infection is an essential component toward controlling and eliminating TB in the United States. Those who were born in or frequently travel to places where TB disease is common are at a greater risk of TB infection. According to the World Health Organization's Global Tuberculosis Report 2024 (WHO, 2024), eight countries accounted for more than two thirds of global TB cases in 2023: India (26%), Indonesia (10%), China (6.8%), the Philippines (6.8%), Pakistan (6.3%), Nigeria (4.6%), Bangladesh (3.5%) and the Democratic Republic of the Congo (3.1%).

While many providers have reported TB infections to NDHHS for years, latent TB infection officially became a reportable condition in North Dakota in 2018. The case definition used by NDHHS follows the guidance of CSTE and CDC. For latent TB infection cases to meet the standardized CSTE case definition, providers must report the laboratory, clinical, and radiologic findings as part of the assessment to rule out active TB disease. The TB Program does not perform chart reviews on electronically reported positive TB tests to obtain missing data elements to confirm TB infection.