ALABAMA INTEGRATED HIV PREVENTION AND CARE PLAN 2027-2031



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Acknowledgments & Thank You!

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Alabama Partners in Care

Alabama Quality Management Group

Organizational Ideas

CDC Prevention funded AIDS Service Organizations and clinics

RW Part C and D funded AIDS Service Organizations and clinics

RW Part B funded AIDS Service Organizations and clinics

The University of Alabama at Birmingham School of Public Health

Southeast AIDS Education and Training Center

United Way of Central Alabama

Acronyms

ADAP	Alabama AIDS Drug Assistance Program
ADOC	Alabama Department of Corrections
ADPH	Alabama Department of Public Health
APCG	Alabama Prevention and Care Group
APiC	Alabama Partners in Care
AQMG	Alabama Quality Management Group
ART	Antiretroviral Therapy
ASO	AIDS Service Organization
CDC	Centers for Disease Control & Prevention
CBO	Community-Based Organization
DIS	Disease Intervention Specialist
eHARS	Enhanced HIV/AIDS Reporting System
EHE	Ending the HIV Epidemic
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HREP	HIV Re-Engagement Program
HRSA	Health Resources and Services Administration
IDU	Injection Drug Use
MMSC	Male-to-Male Sexual Contact
NHAS	National HIV/AIDS Strategy
OHPC	Office of HIV Prevention & Care
PEP	Post-exposure prophylaxis
PrEP	Pre-exposure prophylaxis
PWH	People with HIV
PWID	People who inject drugs
RWHAP	Ryan White HIV/AIDS Program
SE AETC	Southeast AIDS Education Training Center
SSP	Syringe Service Program
STD	Sexually Transmitted Disease

STI	Sexually Transmitted Infection
SUD	Substance Use Disorder
U=U	Undetectable=Untransmittable
UWCA	United Way of Central Alabama

SECTION I: Introduction

The Alabama HIV Prevention and Care Integrated Plan (HIV Integrated Plan) provides a coordinated, data-driven framework to align HIV prevention, care, and treatment efforts statewide. Developed in accordance with the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) Integrated HIV Prevention and Care Planning Guidance, the plan synthesizes epidemiologic, programmatic, and stakeholder-informed data to guide strategic actions that reduce new HIV infections, improve health outcomes for people with HIV (PWH), and address persistent variances across the HIV Care Continuum.

Alabama continues to experience a disproportionate burden of HIV among Black/African American groups, individuals reporting male-to-male sexual contact (MMSC), people who inject drugs (PWID), the Latino population, and residents of rural and vulnerable areas. Structural and social determinants of health, including poverty, housing instability, limited access to healthcare, transportation hindrance, stigma, and medical mistrust, contribute to inconsistent uptake of prevention methods, delayed diagnosis, engagement in care, and viral suppression. These conditions highlight the need for an integrated, system-level approach to HIV planning and service delivery.

Organized around the four pillars of the Ending the HIV Epidemic (EHE) initiative, Diagnose, Treat, Prevent, and Respond, the HIV Integrated Plan outlines measurable goals, objectives, and strategies to expand HIV testing and early diagnosis; strengthen timely linkage to and retention in high-quality, sustained HIV care; increase access to pre-exposure prophylaxis (PrEP) and other proven prevention interventions; and enhance outbreak detection and rapid response capacity. Cross-cutting strategies emphasize workforce development, fairness in health outcomes, stakeholder engagement, data integration, and policy and systems change. These approaches align with EHE priorities and the National HIV/AIDS Strategy (NHAS), reinforcing early diagnosis, rapid linkage to care, sustained viral suppression, and expanded prevention access.

A comprehensive situational analysis informed the plan and the needs assessment, which examined HIV surveillance data, service utilization trends, and gaps across prevention and care systems. Stakeholders provided input through statewide meetings, focus groups, surveys, and key informant interviews. While extensive engagement efforts were undertaken, the plan identifies and addresses participation limitations among certain populations, including individuals with lived experience, tribal entities, and other neglected groups, through targeted strategies.

Needs assessment findings informed the development of integrated goals, objectives, and strategies aligned with NHAS indicators. The plan prioritizes cross-program collaboration between prevention and care, integration of HIV services with sexually transmitted infection (STI), substance use disorder (SUD), and behavioral health services, and the meaningful involvement of PWH in implementation and evaluation activities.

Through coordinated action, continuous monitoring, and sustained partnership, the HIV Integrated Plan serves as a strategic roadmap to reduce HIV-related care gaps, strengthen systems of care, and improve health outcomes for all Alabamians affected by HIV. As a dynamic framework guided by data, accountability, and lived experience, the plan adapts to emerging needs and conditions. By centering those most affected and fostering collaboration across all sixty-seven counties,

Alabama advances toward a future in which HIV is no longer a public health crisis but a preventable condition and a manageable chronic disease.

Mission and Vision

The HIV Integrated Plan reflects the mission and vision of the Office of HIV Prevention and Care (OHPC).

The mission of OHPC is to improve the quality of life for all Alabamians by ending intersecting epidemics impacting HIV and Hepatitis C (HCV) through equitable, accessible, and stigma-free prevention and treatment services.

An Alabama that embraces the dignity of self-respect and universal caring in the human experience when HIV and Hep C are eliminated by leveraging community partnerships.

Strategic Framework for Action

Extensive engagement with stakeholders, providers, and partners was key to developing and submitting the 2027-2031 HIV Prevention and Care Integrated Plan. The planning process for the five-year HIV Integrated Plan kicked off in February 2025 with our biennial "Visioning Day," which focused on identifying priorities and the internal program staff best positioned to develop it.

Visioning Day brings together the Office of HIV Prevention and Care, United Way of Central Alabama, and the AIDS Education and Training Center (AETC) to create a shared vision for the future. It includes generating ideas, examining ambitions, and establishing long-term objectives. The result is a distinct and persuasive vision that can steer future choices and strategic planning.

"Proactive, Thoughtful Planning for the Future" was the theme for the 2025 Visioning Day. The 2025 Visioning Day allowed us to assess aspects of the HIV Integrated Plan. This included identifying successes and challenges, evaluating the current situation of the HIV epidemic in Alabama, examining the organization's mission, vision, and values, engaging in discussions on stakeholder involvement, understanding the resources and needs related to behavioral health, and determining priorities for future actions while using activities to support planning objectives.

UNITED WAY OF CENTRAL ALABAMA

A long-standing organization serving Central Alabama through strategic investments in health, education, and financial stability initiatives. Through its extensive network of nonprofit partners, corporate supporters, and volunteers, UWCA mobilizes resources to address critical social determinants of health that influence HIV prevention and care outcomes, including housing instability, food insecurity, behavioral health needs, and access to supportive services. In partnership with the Office of HIV Prevention and Care, UWCA plays a collaborative role in strengthening referral networks, aligning community-based services with Ryan White HIV/AIDS Program services and prevention programming, and supporting coordinated care efforts that improve linkage to care, retention in care, and viral suppression outcomes for people with HIV.

SECTION II: Community Engagement and Planning Process

Stakeholder engagement is a foundational component of effective public health practice, enabling programs to build trust, foster collaboration, and ensure that interventions respond to the needs and priorities of the populations they serve. Through structured partnerships, participatory decision-making processes, and continuous dialogue, stakeholder engagement facilitates the incorporation of various perspectives and lived experiences in program planning, implementation, and evaluation. This approach strengthens the social relevance and acceptability of interventions, enhances accountability, and supports shared ownership of health initiatives. By empowering members of the public to contribute their expertise and insights, engagement efforts help identify emerging challenges, illuminate contextual factors that influence health behaviors, and generate innovative, locally informed solutions. Ultimately, sustained stakeholder engagement supports a just, effective, and resilient public health system. This method is a vital element of Alabama's HIV Integrated Plan; it ensures that strategic efforts reflect the lived realities of people most affected by HIV. By systematically involving PWH, AIDS Service Organizations (ASOs), Community-Based Organizations (CBOs), healthcare providers, and public health agencies, the approach strengthens the plan's relevance and effectiveness, helping identify local constraints to care, reveal unmet needs, and highlight specific considerations that might otherwise be overlooked. Sustained engagement enhances transparency, accountability, and shared ownership of program goals, ultimately promoting fairness and supporting the development of more comprehensive, responsive, and sustainable outcomes across the full HIV prevention and care continuum.

To ensure the integrated plan prioritized the needs of people affected by HIV, engagement activities focused on organizations and individuals who could represent the populations of focus and the various groups that make up the state of Alabama.

Integrated Planning Process

A multi-phased method guides the development of the HIV Integrated Plan (2027–2031), ensuring data-driven strategies and robust stakeholder representation. The initial phase, spanning from February to July 2025, established the foundational planning architecture. Central to this stage is the formal engagement of the University of Alabama at Birmingham School of Public Health (UAB-SOPH) to spearhead a comprehensive HIV needs assessment. This period focused on identifying priority populations and establishing the HIV Integrated Governing Body, which serves as the primary governing body for defining the information-gathering protocols and the project's overarching timeline.

Following the establishment of the planning structure, the process progressed into a comprehensive information-gathering phase from August 2025 through January 2026. This stage combined targeted HIV needs assessment surveys, focus groups, and a broad community survey to

HIV Governing Body

Meeting at the beginning of each planning phase of the integrated planning process, the HIV governing body convene to provide coordinated oversight, guidance, and strategic direction to the HIV integrated planning process. Membership includes designated representatives from:

- Ryan White HIV/AIDS Program (RWHAP) Part B
- HIV Prevention
- HRSA & CDC EHE

capture both quantitative trends and lived experiences, including knowledge, prevention practices, and service utilization. Transparency and all-embracing principles were central to the process, supported by regular updates provided to the public and partner organizations to foster trust, shared ownership, and sustained engagement. The community survey supplemented the statewide needs assessment by identifying knowledge gaps among lay members and highlighting areas for public health interventions to strengthen prevention efforts. The OHPC team and partners received updates through Alabama Partner in Care (APiC) conferences, Alabama Prevention and Care Group (APCG) meetings, structured stakeholder briefings, and monthly OHPC team and subrecipient meetings, ensuring partners remained actively informed. Planning representatives also engaged residents directly at events such as health fairs, STI/HIV college screenings, Homeless Connect, and back-to-school initiatives, facilitating bidirectional dialogue, gathering input, and providing participation incentives to encourage broad engagement. These efforts enhanced data validity, elevated public perspectives, and ensured that the integrated plan reflected both quantitative trends and authentic, stakeholder-informed priorities. The phase concluded with the systematic synthesis of collected data, establishing a vetted foundation to guide the development of subsequent strategic pillars.

The final phase, beginning in early 2026, focused on drafting, reviewing, and publishing the integrated strategy. Findings from the needs assessment were shared with stakeholders, and proposed goals and objectives were shared with APCG voting members and stakeholders to review and offer feedback on draft priorities and strategies. Following the incorporation of stakeholder input, the plan underwent final revisions in June 2026, resulting in the publication of a coordinated, statewide strategy ready for implementation beginning in 2027.

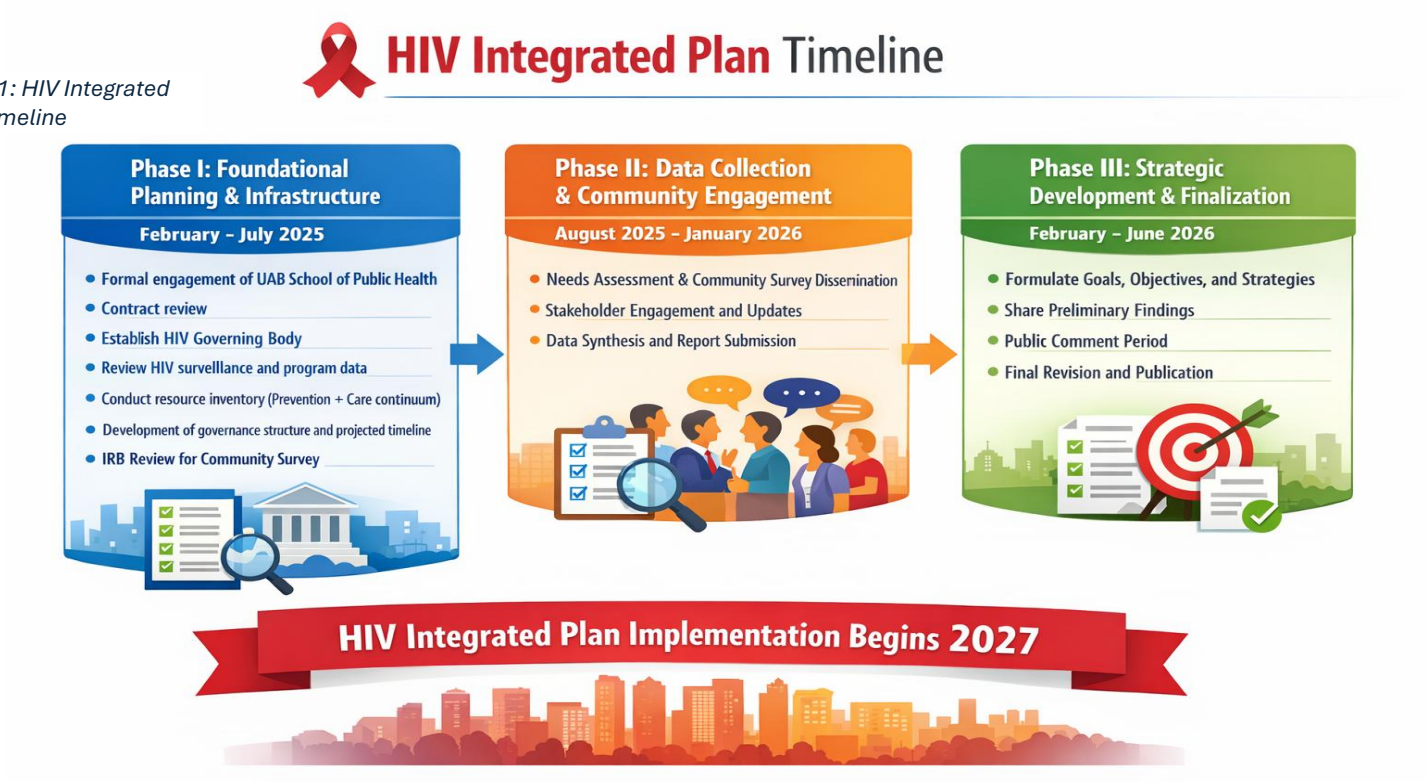


Figure 1: HIV Integrated Plan Timeline

Community and Organizational Engagement

The HIV integrated process engaged a broad range of entities across the prevention, care, and supportive services sectors in Alabama to ensure comprehensive stakeholder input. Participating organizations included Ryan White HIV/AIDS Program (RWHAP) Part B subrecipients, Part C and D clinics, county health departments, ASOs, CBOs, behavioral health providers, federally qualified health centers, support groups, and other stakeholders serving people with HIV and populations vulnerable to HIV acquisition. Invitations to participate were extended via email, public engagement, personal conversations, and direct engagement with program HIV managers and the HIV Re-Engagement Program (HREP) to encourage organizational involvement in surveys, focus groups, or key informant interviews. While several organizations expressed initial interest, a subset ultimately declined participation due to decisions made at higher levels of organizational leadership, reflecting broader constraints such as competing priorities or administrative limitations. Despite these declines, the organizations that participated contributed various perspectives across geographic regions, service delivery models, and population focus areas, including rural and urban districts disproportionately affected by HIV. Their engagement ensured a broad representation of providers, consumers, and system-level stakeholders, thereby strengthening the validity of the findings and reflecting the multifaceted landscape of HIV prevention and care across Alabama.

1917 Community Engagement Council

AIDS Service Organizations

Alabama Prevention and Care Group

Alabama State University

Awakening Recovery

Behavioral Health Group (BHG)

Blackbelt Wellness

Chi Eta Phi Mu Eta Nursing Sorority

Client Care Continuum

Community-Based Organizations

County Health Departments

Healing Network of Walker County

Homeless Connect – Calhoun County

Hope For Women

Indian Rivers Community Mental Health

Northwest Alabama Mental Health Center

Peer 251 Support Group

Phoenix House

Rural Alabama Prevention Center Wellness Conference

Ryan White HIV/AIDS Program Providers

Shelton State Community College Nursing

Stillman College

Sumter County Coalition

Tuscaloosa Latino Coalition

Tuscaloosa Probation, Pardons & Parole

Walker Recovery

West AL HIV Prevention Network

Shared Vision, Shared Responsibility

Alabama receives federal HIV funding from multiple sources, including RWHAP Part B, HRSA EHE, CDC EHE, and CDC Prevention and Surveillance. Through a shared vision and collaborative planning process, the OHPC coordinated activities, including Prevention Planning, HIV Care Continuum Planning, and the development of the 5-Year Integrated HIV Prevention and Care Plan. This coordinated approach helps maximize resources, reduce duplication, address service gaps, and support HIV testing, linkage to care, retention in care, viral suppression, program planning, and evaluation, advancing Alabama's efforts to end the HIV epidemic.

Alabama Partners in Care

Alabama Partners in Care (APiC) is a statewide coalition comprising 17 organizations that collaborate with the Alabama Department of Public Health (ADPH) Office of HIV Prevention and Care and United Way of Central Alabama. This coalition assists individuals with HIV in obtaining necessary healthcare, support services, and resources across the state. Conducted biannually, the APiC Conference convened HIV care providers throughout Alabama for collective learning, inter-agency cooperation, and professional advancement. These in-person meetings support the establishment of stronger partnerships, showcase innovative practices, and synchronize statewide initiatives to enhance outcomes for individuals living with HIV and AIDS.

The APiC Conference has historically focused on RWHAP care activities. In 2025, the spring conference included HIV prevention staff to reflect a broader, status-neutral approach, recognizing the importance of integrating prevention and care to strengthen outcomes across the HIV continuum**.** The *Alabama Integrated HIV Prevention and Care Planning for All* session emphasized the importance of building shared ownership and stakeholder engagement in developing Alabama's Integrated HIV Prevention and Care Plan for 2027–2031. Attendees participated in a dynamic breakout group activity to develop outreach strategies for various populations. Each group was assigned a population of focus and tasked with identifying innovative, socially aware methods to inform the integrated planning process. Participants documented ideas on newsprint and provided report-backs later in the conference. Key focus groups included:

1. Youth/High School Adolescents
2. Adults 55+
3. Rural Towns
4. Latino Population
5. Social Service Providers
6. Tribal Organizations/Native Nations
7. Federally Qualified Health Centers (FQHC)
8. Justice-Involved
9. Unhoused Individuals
10. Cross-Cutting challenges, excluding transportation

Alabama Prevention and Care Group

The Alabama Prevention and Care Group, formerly known as the HIV Prevention and Care Group (HPCG), serves as a collaborative advisory body. The APCG brings together various stakeholders, including people with lived experience, ASOs, healthcare providers, public health agencies, and

supportive partners. The group provides a structured forum for sharing data, identifying emerging needs, and offering participatory feedback on HIV prevention, care, and treatment strategies. Through quarterly meetings and stakeholder engagement, the group supports alignment of statewide HIV initiatives with shared priorities, encourages coordination across prevention and care systems, and ensures that planning and implementation efforts are responsive to the needs of populations most disproportionately affected by HIV.

Transparency and stakeholder engagement were further strengthened during the August Quarterly meeting through an interactive Kahoot! session titled *HIV Prevention and Care Integrated Plan: Envisioning the Future*. This innovative engagement strategy created a broad and participatory environment in which members reviewed key data trends, reflected on progress, and contributed ideas to shape future priorities. Through facilitated discussion and real-time polling, APCG members identified strategies to:

1. Leverage innovation and technology to improve HIV prevention and care outcomes,
2. Strengthen partnerships and collaboration to engage a broader range of stakeholders, and
3. Address persistent challenges across the HIV Care Continuum.

This interactive approach reinforced transparency by openly sharing planning updates, incorporating stakeholder feedback into strategy development, and fostering collective ownership of the Integrated Plan. Guided by the goals of the Ending the HIV Epidemic initiative and reflecting on the mission and vision of the Office of HIV Prevention and Care, the APCG affirmed a future vision of Alabama where HIV is no longer a public health threat and all residents have universal access to high-quality prevention, care, and treatment services free from stigma and structural impediments.

Strengthening Impact Through Ryan White Partnerships

Alabama Quality Management Group

The Alabama Quality Management Group (AQMG) is integrated into the HIV Integrated Plan to support ongoing quality improvement across HIV services in Alabama. Led by representatives from RWHAP Part C and Part D providers, the group does not hold direct oversight, monitoring, or evaluation authority. Still, it serves as a multidisciplinary forum to guide best practices. Its representation includes Ryan White HIV/AIDS Programs (Parts B, C, and D), clinicians, administrators, and researchers from the Center for AIDS Research (CFAR), fostering collaboration and ensuring that quality management efforts reflect both clinical expertise and stakeholder perspectives.

The AQMG supports the HIV Integrated Plan by:

1. **Monitoring and analyzing performance:** Tracking key HIV continuum indicators such as linkage to care, retention, and viral suppression across funded programs.
2. **Guiding quality improvement:** Recommending and facilitating initiatives to enhance clinical and organizational practices in RWHAP Part C and D agencies and other service providers.

3. **Aligning with plan objectives and national priorities:** Using data and empirically supported strategies to support Integrated Plan goals and initiatives, such as the EHE strategy.

Through its collaborative structure, which incorporates RWHAP and CFAR researchers, the AQMG ensures that the HIV Integrated Plan is evidence-informed, accountable, and responsive, thereby promoting continuous improvement and measurable outcomes in HIV prevention and care.

To introduce the HIV Integrated Plan's strategic framework in an engaging, approachable manner, RWHAP Part C and Part D providers participated in an interactive Kahoot! Activity titled *HIV Prevention and Care Integrated Plan: Learn and Grow*. This learning approach was designed to reinforce key elements of the Integrated Plan while fostering shared understanding of priorities, roles, and cross-part collaboration. By using a game-based format, the activity fosters active learning, knowledge retention, and dialogue among providers who play a critical role in the HIV Care Continuum.

The Kahoot! activity specifically highlights how RWHAP Part C and Part D providers can support and complement RWHAP Part B efforts within the HIV Integrated Plan. As primary sources of outpatient medical care, early intervention services, and family-centered care, Part C and Part D providers are uniquely positioned to advance integrated goals, including rapid linkage to care, retention, viral suppression, and universal access to services. The activity underscored opportunities for alignment across care coordination, data sharing, referral pathways, and the social determinants of health affecting PWH throughout the lifespan.

RWHAP F

The AL AETC, a partner of the Southeast AIDS Education and Training Center (SE AETC), is incorporated into the HIV Integrated Plan as a key partner in workforce development, capacity building, and technical assistance. SE AETC works closely with health departments, Ryan White HIV/AIDS Programs, and ASOs to ensure that training and educational initiatives align with jurisdiction-specific priorities and identified gaps in HIV prevention and care services.

Through its integration into the plan, SE AETC:

1. **Supports workforce development:** Provides targeted education and training for clinicians and healthcare teams to implement validated HIV prevention, diagnosis, treatment, and care practices.
2. **Facilitates plan implementation:** Offers technical assistance and guidance to help providers operationalize Integrated Plan strategies, including PrEP delivery, linkage to care, retention, and viral suppression.
3. **Aligns with quality and performance goals:** Partners with stakeholders to strengthen organizational systems, support practice transformation, and advance measurable outcomes aligned with national initiatives, including the EHE strategy.

By incorporating SE AETC into the HIV Integrated Plan, Alabama leverages its expertise to enhance provider capacity, improve service delivery, and ensure implementation of HIV prevention and care strategies.

Centering the Voices of People with HIV

The Statewide HIV Needs Assessment served as a key source of primary data used to identify the care and service needs of people with HIV across Alabama. To support the 2025–2026 Statewide Needs Assessment, a survey was administered to clients receiving HIV/AIDS-related medical care and supportive services throughout the state. The survey, available in both English and Spanish, was distributed through agencies providing HIV/AIDS services and utilized a self-administered questionnaire format. Eligible clients were invited to participate between July and December 2025.

To further explore the trends and themes identified through the survey findings, a series of focus groups was conducted across Alabama. These discussions brought together participants from various geographic regions, demographic backgrounds, and stakeholder perspectives to deepen understanding of the experiences reflected in the quantitative data. Facilitators used guided discussion questions to encourage meaningful dialogue, including prompts on impediments to care, service accessibility, unmet needs, and recommendations to improve HIV prevention and care services statewide. The open discussion format allowed participants to share personal experiences, expand on survey responses, and identify emerging concerns that may not have been fully captured through the survey process alone.

The focus groups provided valuable context for understanding the underlying factors influencing care engagement and service utilization. In many instances, participants validated trends identified in the survey data and offered additional insights into the lived experiences, challenges, and priorities of PWH. These conversations strengthened the overall needs assessment process by ensuring people with lived experience voices remain central to the interpretation of findings and future planning efforts.

Consumer Advisory Listening Sessions

1. Peer 251 Support Group
2. Blackbelt Wellness
3. 1917 Community Engagement Council

As a final layer of stakeholder engagement, Consumer Advisory Review and Listening Sessions were conducted to gather additional recommendations and concerns regarding Alabama's HIV Prevention and Care Integrated Plan. Participants received an HIV Integrated Plan "At-A-Glance" Summary Packet that included a summary of the Integrated Plan, identified priorities, a Needs Assessment Summary, an overview of the 2027–2031 HIV Integrated Workplan, and the five-year Roadmap for Impact, which outlines implementation, monitoring, and follow-up activities. Facilitated discussions were designed to encourage active participation and meaningful feedback through targeted questions about the plan's priorities, feasibility, service gaps, and opportunities for improvement. Participants were also asked to reflect on whether the proposed strategies aligned with the current needs and experiences of HIV prevention and care services within their communities.

Feedback gathered during the review, listening, and feedback sessions provided important stakeholder perspectives that informed the refinement of the HIV Integrated Plan and strengthened its direction for the next five years. Participant recommendations helped identify areas requiring additional emphasis, clarification, or modification to address impediments to care, improve

service coordination, and strengthen statewide prevention and treatment efforts. Once these perspectives were synthesized and incorporated, the plan underwent a final revision, resulting in the publication of a coordinated statewide strategy for implementation in 2027. The inclusion of PWH perspectives throughout the assessment and planning process ensured that the HIV Integrated Plan remained community-informed, responsive, and reflective of the evolving needs of individuals and communities affected by HIV in Alabama.

Another avenue for engaging PWH was through the HIV Re-Engagement Program (HREP). HREP has been instrumental in identifying individuals who have fallen out of care and supporting their return to consistent medical engagement. HREP consists of licensed ADPH social workers who are responsible for locating individuals who are HIV positive and have not received care for over a year. Using data-to-care strategies, outreach partnerships, and tailored case management, the program systematically locates individuals who have missed appointments, discontinued treatment, or otherwise disengaged from the care continuum. Once identified, participants are offered personalized support that addresses the multifaceted hindrances contributing to disengagement, including transportation challenges, stigma, behavioral health needs, and unstable housing. By providing navigation services, linking individuals to supportive resources, and providing ongoing follow-up, the program helps individuals reestablish relationships with healthcare providers and resume antiretroviral therapy. Importantly, HREP's assistance has created opportunities for individuals to voice their experiences, concerns, and preferences, ensuring that re-engagement efforts are responsive, respectful, and aligned with their needs. This client-centered approach contributes not only to improved health outcomes and strengthened viral suppression rates but also to greater empowerment and meaningful participation within the broader HIV care system.

Focus Areas for Action

Quantitative data, including epidemiologic trends and service utilization patterns, highlight persistent gaps across the HIV prevention and care continuum. Complementing these data, qualitative insights gathered through focus groups, interviews, and surveys provide critical context regarding lived experiences, access challenges, and emerging needs within affected regions.

Statewide engagement efforts bring together people with HIV, ASOs, healthcare providers, and public health stakeholders to review these findings and identify shared priorities. This collaborative and data-driven approach ensures that priority areas are responsive to public needs, encourages fairness in health outcomes, and reflects real-world conditions.

Through this integrated planning process, including data analysis and input from the Alabama Prevention and Care Group, several key priority areas emerged.

1. Strengthening HIV Medical Care and Support Services

Expand access to high-quality, socially aware HIV medical care and support services across the state. Efforts will focus on ensuring individuals are diagnosed early, rapidly linked to care, retained in treatment, and supported in achieving and maintaining sustained viral suppression.

2. Addressing Social Determinants of Health

Address social and structural impediments that impact health outcomes for people with and vulnerable to HIV acquisition. Key areas include housing stability, transportation, access to

healthcare, food security, and economic opportunity, all of which influence engagement in care and prevention services.

3. Integrating Behavioral Health and Substance Use Services

Enhance the integration of behavioral health and substance use services within the HIV prevention and care continuum. Strengthening access to behavioral health services will support improved engagement in care, treatment adherence, and long-term health outcomes.

4. Strengthen HIV Prevention Efforts (Testing, Education, and Awareness)

Increase awareness and understanding of effective HIV prevention strategies, including routine testing, Pre-Exposure Prophylaxis (PrEP), Post-Exposure Prophylaxis (PEP), and harm reduction strategies. Targeted outreach and education efforts will focus on people disproportionately affected by HIV.

5. Reducing HIV-Related Stigma and Judgment & Building Stakeholder Trust

Implement strategies to reduce stigma and judgment associated with HIV, which remain significant hindrances to testing, prevention, treatment engagement, and overall well-being. Efforts will focus on public education, provider training, and policies that foster welcoming and supportive environments.

6. Strengthening the HIV Workforce

Support recruitment, retention, and professional development of the workforce serving individuals living with HIV and those vulnerable to HIV acquisition. Building workforce capacity will improve service delivery, expand access to care, and strengthen the overall effectiveness of HIV prevention and treatment programs across Alabama.

SECTION III: Contributing Data Sets and Assessment

Data Sources and Surveillance Systems

The following are internal and external data sources and systems that provide qualitative and quantitative information to support program planning for HIV surveillance, prevention, and care services.

Data Sources	Description
Alabama's HIV/AIDS Disease Information System (HADIS)	HADIS provides significant data in determining the demographic and geographical location of HIV positive Alabama residents who are aware of their HIV status and not in care. HADIS also contains counseling and testing data for CDC-funded test kits.
Enhanced HIV/AIDS Reporting System (eHARS)	A web-based system used by U.S. health departments to report, manage, and analyze data on HIV and AIDS cases to the Centers for Disease Control and Prevention (CDC). It collects individual case information, such as demographics, risk factors, and lab results, which is then used for public health surveillance to monitor the epidemic, plan prevention programs, and evaluate the effectiveness of interventions.
Alabama National Electronic Disease Base Surveillance System (ALNBS)	An integrated surveillance information system that supports public health investigation workflow and processes, analyzes, and shares disease-related health information.
United States Census Bureau	The Census Bureau collects and provides information about the people and economy of the United States. The Census Bureau's website includes data on the demographic characteristics of the population, family structure, educational attainment, income levels, housing status, and the proportion of people living at or below the federal poverty level.
Ryan White Service Report (RSR)	A client-level data reporting system for HRSA-funded recipients and sub-recipients. It tracks demographic, clinical, and service-use data to monitor program performance, ensure quality care for people with HIV, and demonstrate the impact of RWHAP funding nationwide.
Alabama Sexually Transmitted Disease (STD) Report	The ADPH Division of STD conducts statewide surveillance to determine the number of reported STD cases and monitor trends.

Figure 2: Alabama Department of Public Health District Map



Alabama ranks as the 30th- largest and the 24th- most populous state, located in the southeastern part of the United States. In 2024, the population of Alabama was projected to be 5.1 million, representing a 2.6% increase from the figures reported in 2020, according to the U.S. Census Bureau. The State of Alabama comprises 67 counties, ranging in population from 7,100 (Greene County) to 674,721 (Jefferson County) residents. Alabama is considered a rural state; however, 12 counties (Lauderdale, Madison, Morgan, Etowah, Calhoun, Jefferson, Tuscaloosa, Shelby, Montgomery, Lee, Mobile, and Houston) are considered urban.

Although the predominant demographic in Alabama is Caucasian (68.9%), the state also exhibits a significant African American population (26.6%) and an expanding Latino population (5.7%). The median age in Alabama is 39.6 years, with females constituting approximately 51.5% of the population.

As of 2019-2023, the median household income in Alabama is projected to be $62,027, compared to the national median of $78,538, and the per capita income is $34,835. Approximately 15.6% of

Alabama's population resides below the poverty line, with poverty rates being more elevated in rural areas than in urban regions. Although the median household income in Alabama is below the national average, its educational attainment is on par with the nation: 89% of adults are high school graduates, and 29% hold a bachelor's degree or higher.

Alabama at a glance:

- 2,123,399 residents, or 42.3% of Alabama's entire population, live in rural areas.
- The average percentage of uninsured Alabama residents aged 18 to 64 who live in rural areas is 16.4 percent, compared to 14.1 percent of residents who live in urban areas.

Access to Healthcare Poses a Challenge in Rural Alabama

- There are 54 rural county hospitals serving residents in 42 of Alabama's 55 rural counties.
- Only 15 rural counties in Alabama have labor and delivery units.
- Across the state, 28% of women in Alabama have no birthing hospital within 30 minutes of their residence.
- In rural areas throughout Alabama, 89.8% of women live more than 30 minutes from a birthing hospital, compared to 26% of women living in urban areas.
- The average emergency response time from call to arrival at the scene for the state is less than 7 minutes. The average response time in urban counties is 0-5 minutes, and in rural counties, 11-15 minutes. However, it can take up to 30 minutes for some rural counties, such as Perry and Clarke.
- Alabama has six critical access hospitals.
- In rural counties, there are 3.2 dentists per 10,000 residents, compared to 5.5 in urban counties in Alabama.
- Hospitals in rural Alabama counties have 21.4 general hospital beds per 10,000 residents, compared to 34.6 general hospital beds per 10,000 residents in urban counties. (*At a Glance | Alabama Department of Public Health,* 2024)

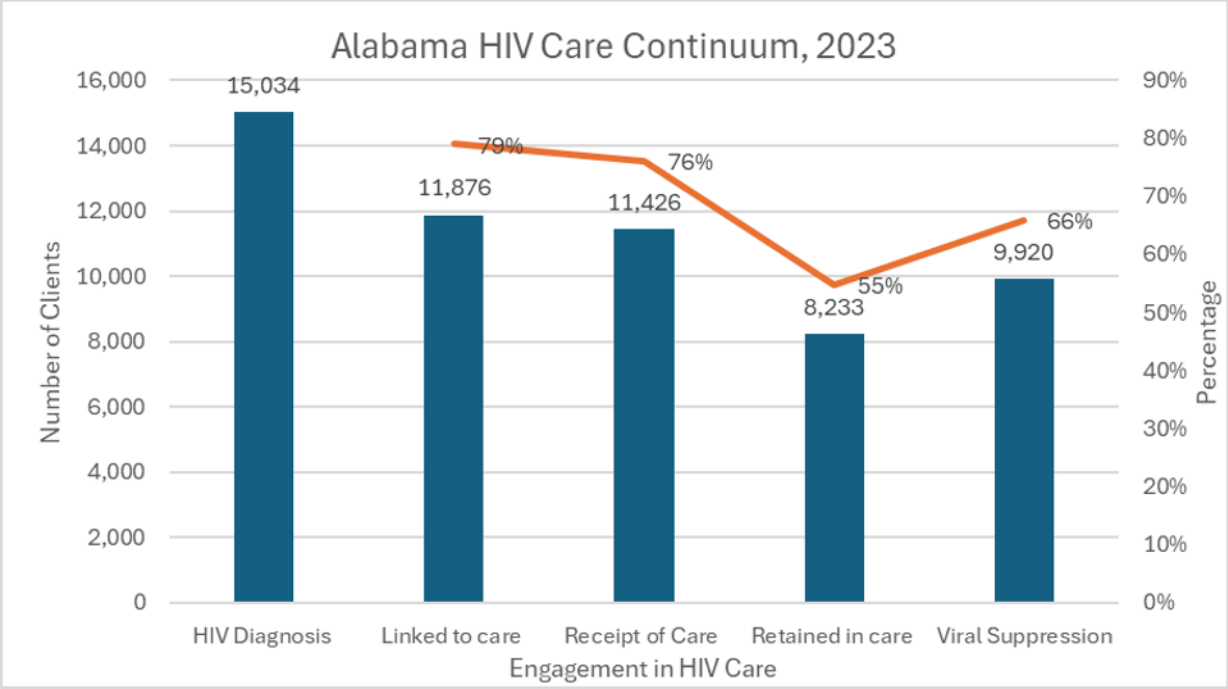
Prevalence of PWH in Alabama

The rate of people with HIV (PWH) in Alabama in 2023 was 312.3 per 100,000 population, with the majority of PWH living in urban counties. However, a high proportion of PWH live in smaller, more rural counties, such as Barbour, Bullock, Chambers, Russell, Macon, Dallas, Greene, Sumter, and Perry. Among PWH, 61% were Black, 27% were White, 7% were multiracial, and 4% were Latino. Persons aged 55-64 accounted for 23% of HIV cases, followed by 35-44 (21%),45-54(20%), and 25-34(19%). Male-to-male sexual contact (MMSC) was the mode of exposure for 60% of males. Heterosexual contact was the mode of exposure for 28% of females. Seven percent (7%) of PWH had a history of injection drug use. Less than 0.01% of the transmission category was documented as "unknown" or "other". There were no perinatal cases reported in 2023.

HIV Care Continuum

The HIV Care Continuum is a diagnosis-based model that reflects the stages from initial diagnosis through retention in care to achieving viral suppression. The HIV Care Continuum has four main stages: HIV diagnosis, linkage to care, retention in care, and viral suppression. It demonstrates the proportion of individuals diagnosed and living with HIV who are engaged at each stage. This model is used by federal, state, and local agencies to identify issues and opportunities to improve service delivery to PWH across the HIV continuum.

Table 1: Alabama HIV Care Continuum, 2023



HIV Diagnosis: All individuals living with HIV reported in Alabama by the end of 2023 who were still alive and living in Alabama by the end of 2023 (15,034 people).

Linked to care: Seventy-nine percent (79%) were linked to care within three months of diagnosis. Linked to care is calculated as the percentage of people receiving a diagnosis of HIV in a given calendar year (during 2023) who had ≥1 CD4 and/or viral load test within 30 days (1 month) of diagnosis.

Receipt of care: Of 15,034 PWH in Alabama in 2023, 76% had at least one laboratory test available in the HIV surveillance system as evidence of receiving care. Receipt of care is calculated as the percentage of PWH who accessed any care in 2023, as evidenced by ≥1 CD4, viral load, and/or HIV genotype test collected in 2023.

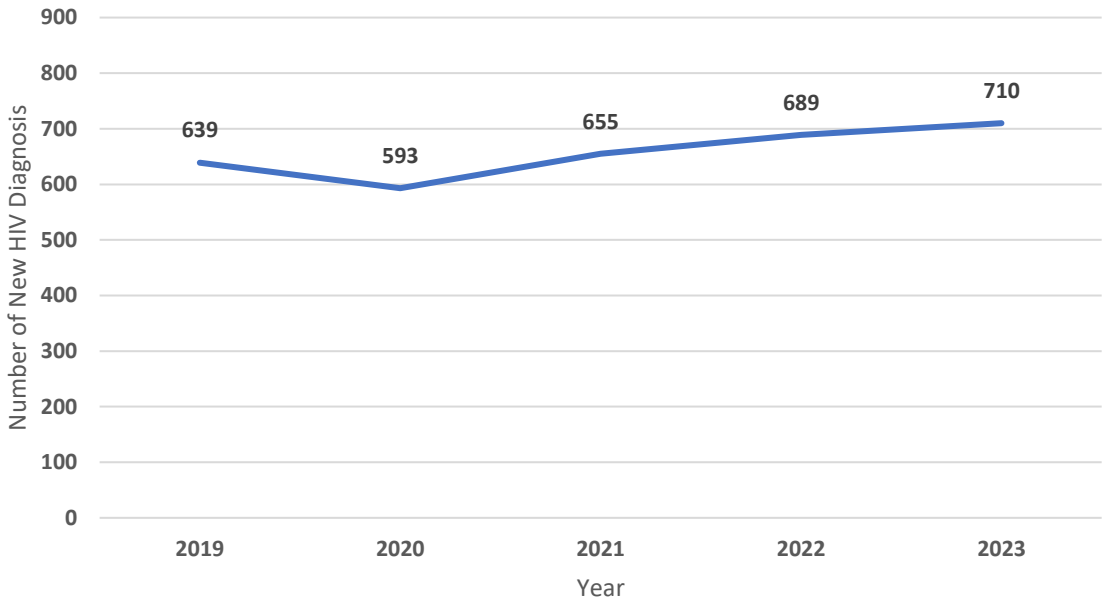
Retained in care: Of 15,034 individuals diagnosed and living with HIV in Alabama during 2023, 8,233 (55%) had laboratory test results that suggested two or more medical visits occurred at least three months apart during the reporting period. Retention in care is calculated as the percentage of PWH who accessed continuous care in 2023, as evidenced by ≥2 CD4, viral load, and/or HIV genotype tests collected at least 90 days apart.

Viral suppression: Of 15,034 PWH in Alabama, 66% had viral loads (<200 copies/mL). Viral suppression is calculated as the percentage of PWH who had a suppressed viral load at the last viral load collected during 2023. Viral suppression improves the health of the PWH and prevents them from transmitting HIV sexually to partners.

Five-Year Trend & New Incidence[1]

Three thousand two hundred and eighty-six (3,286) new HIV infections were diagnosed from 2019 to 2023, showing an upward trend in new HIV cases. The 2020 decline in new cases may, in part, reflect decreased testing and stay-at-home orders related to COVID-19 pandemic control measures. Seven hundred and ten (710) people were newly diagnosed with HIV in 2023.

Table 2: New HIV Diagnosis Cases in Alabama by Year of Diagnosis, 2019-2023



From 2019 to 2023, males consistently experienced a significantly higher rate of new HIV diagnoses compared to females. During this period, the annual diagnosis rate among males remained nearly five times that of females, increasing from 25.6 per 100,000 in 2019 to 28.2 per 100,000 in 2023. In contrast, female diagnosis rates remained relatively stable, ranging from 6.2 to 7. 1 per 100,000 before slightly decreasing to 5.6 in 2023.

In 2023 alone, males accounted for 82% of new HIV diagnoses statewide.

[1] Due to the impact of COVID-19 pandemic, data for 2020 and 2021 should be interpreted with caution. The COVID-19 pandemic disrupted various sectors, including healthcare and public health services, by reducing screening, allocating resources, and leading to widespread lifestyle changes that altered behaviors and data collection methods.

Table 4: New HIV Diagnosis Rates Among Adults/Adolescents by Sex at Birth, 2019-2023

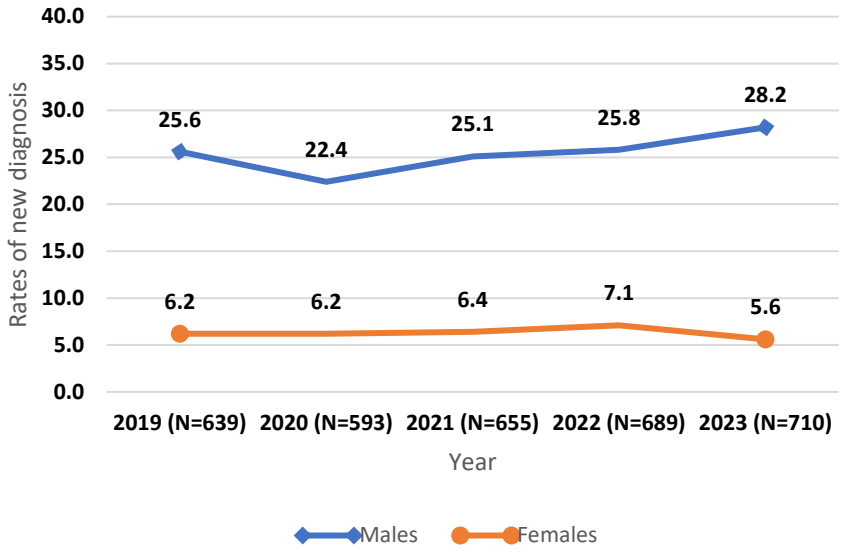
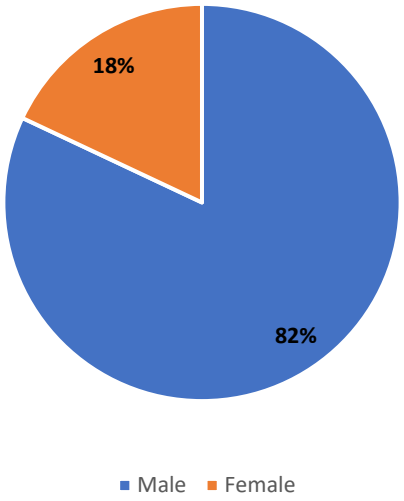
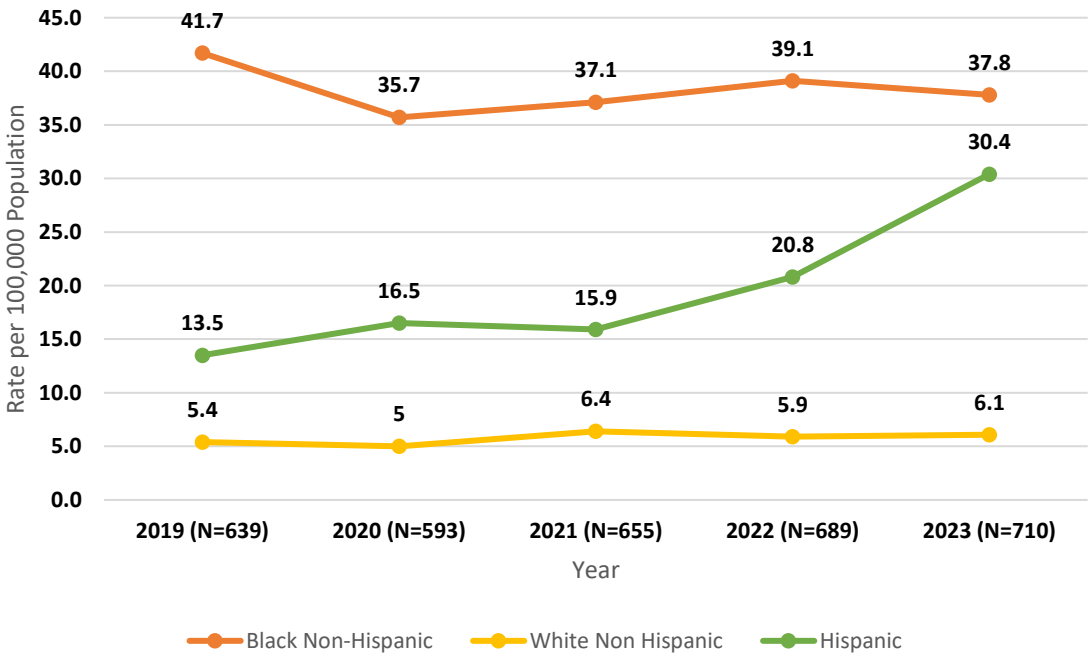


Table 3: New HIV Diagnosis Among Adults/Adolescents by Sex at Birth, 2023



From 2019 to 2023, new HIV diagnosis rates in Alabama remained disproportionately high among Black non-Hispanic residents compared to other racial and ethnic groups. Although rates among Black non-Hispanic individuals declined from 41.7 per 100,000 in 2019 to 35.7 in 2020. They increased again to 39.1 in 2022, then slightly decreased to 37.8 in 2023, and have consistently remained the highest among all groups. Latino residents experienced a notable upward trend, with rates rising from 13.5 per 100,000 in 2019 to 30.4 per 100,000 in 2023, representing the largest increase over the five years. In contrast, rates among White non-Hispanic residents remained comparatively low and stable.

Table 5: New HIV Diagnosis among Adults/Adolescents by Demographic, 2019-2023



In 2023, Black non-Hispanic individuals accounted for 59.5% of the 710 new diagnoses, followed by White non-Hispanic (24.6%), Latino (9%), multiracial (5.9), and other/unknown (1%).

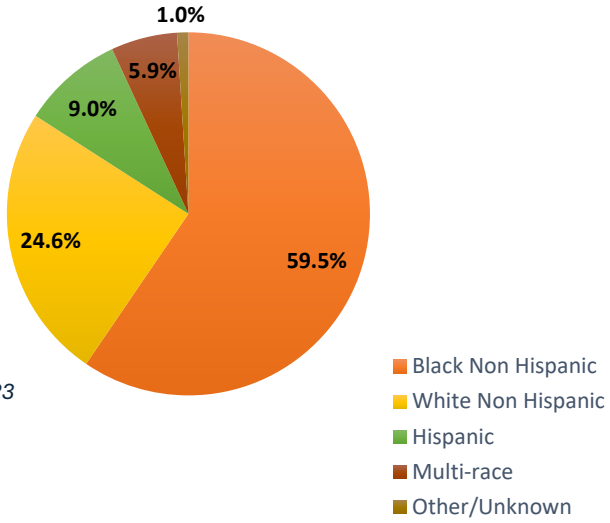


Table 6: New HIV Diagnosis among Adults/Adolescents by Demographic, 2023

From 2019 to 2023, young adults consistently experienced the highest rate of new HIV diagnoses in Alabama. Individuals aged 20-24 and 25-34 had the greatest burden, with rates remaining substantially higher than those of other age groups throughout the five years. In 2023, the rate among those 25-34 reached 40.7 per 100,000 population, while the 20-24 age group followed closely at 38.4 per 100,000. Rates among individuals aged 35-44 fluctuated but remained elevated compared to older age groups, whereas rates among those aged 45-54, 55-64, and 65+ were considerably lower and relatively stable over time.

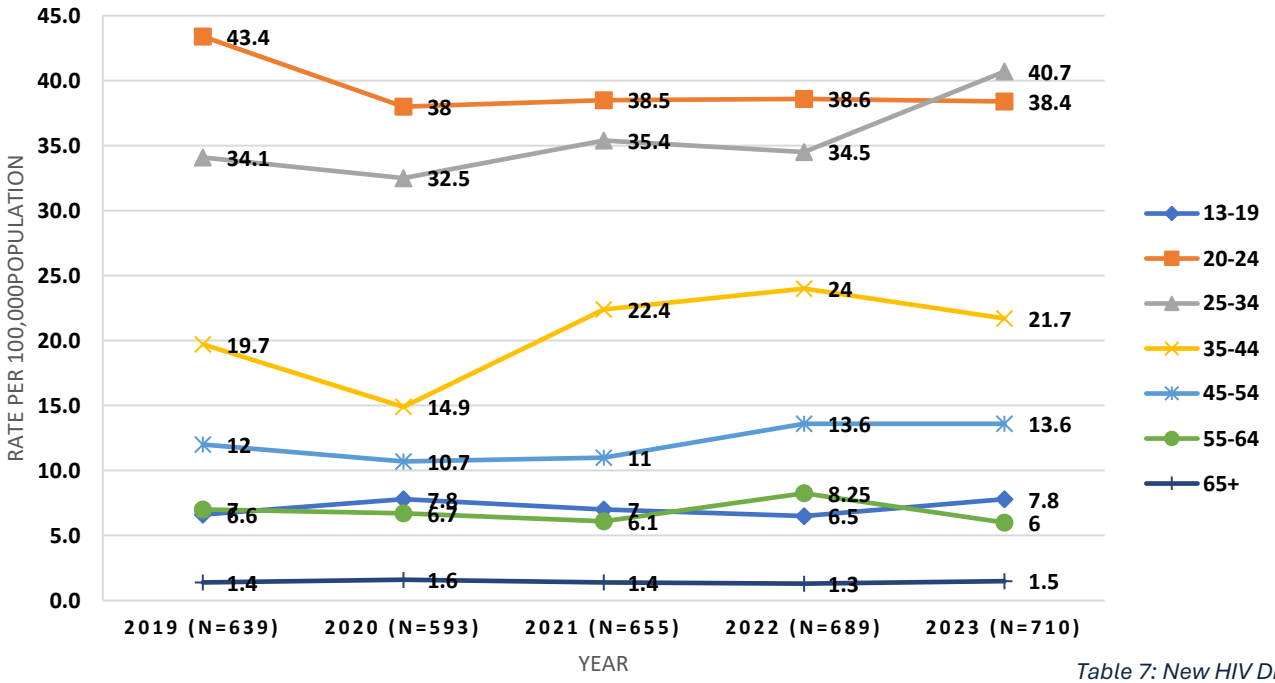
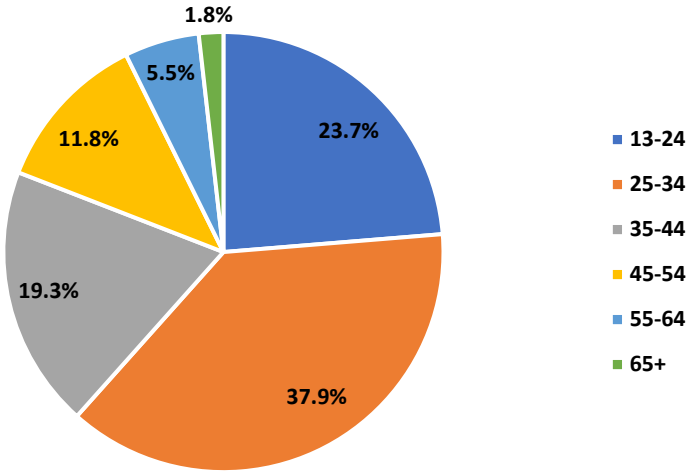


Table 7: New HIV Diagnosis among Adults/Adolescents by Age, 2019-2023

In 2023, persons aged 25*34 accounted for he largest proportion, more than 1/3 of new diagnoses (37.9%), followed by those aged 13-24 (23.7%), and 35-44 (19.3%).

Table 8: New HIV Diagnosis among Adults/Adolescents by Age, 2023



In 2023, new HIV diagnoses continued to reflect significant differences across sex at birth, transmission category, and demographic. Among males, male-to-male sexual contact (MMSC) remains the primary driver of the epidemic, accounting for 89.9% of all new diagnoses. While Black non-Hispanics represent the largest proportion of these cases at 58.7%, there is a notable five-year upward trend among Latino males, whose share of new MMSC-related diagnoses grew from 3.2% in 2019 to 10.1% in 2023.

Table 9: New HIV Diagnosis by Adult/Adolescent Males based on Sex at Birth by Transmission Category, 2023

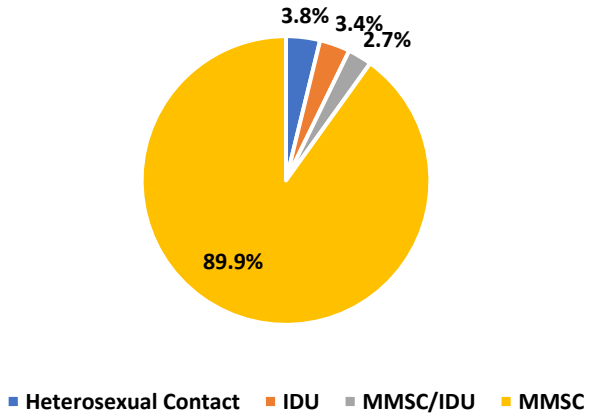
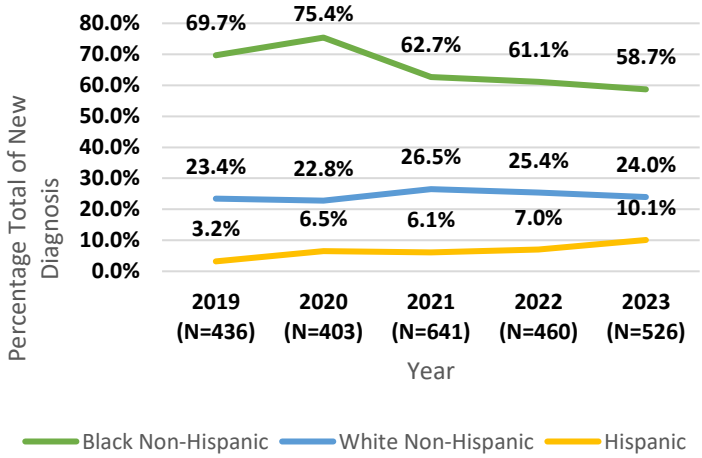


Table 10: New HIV Diagnosis by Adult/Adolescent Males based on Sex at Birth Attributed to MMSC by Demographic, 2019-2023



Conversely, the female epidemic is almost exclusively driven by heterosexual contact (90.4%), with injection drug use (IDU) accounting for 8.8% of cases. Black non-Hispanic women remain disproportionately impacted, representing 65.8% of new diagnoses attributed to heterosexual contact in 2023.

Table 11: New HIV Diagnosis among Adult/Adolescent Females Based on Sex at Birth Attributed to Heterosexual Contact by Demographic, 2019-2023

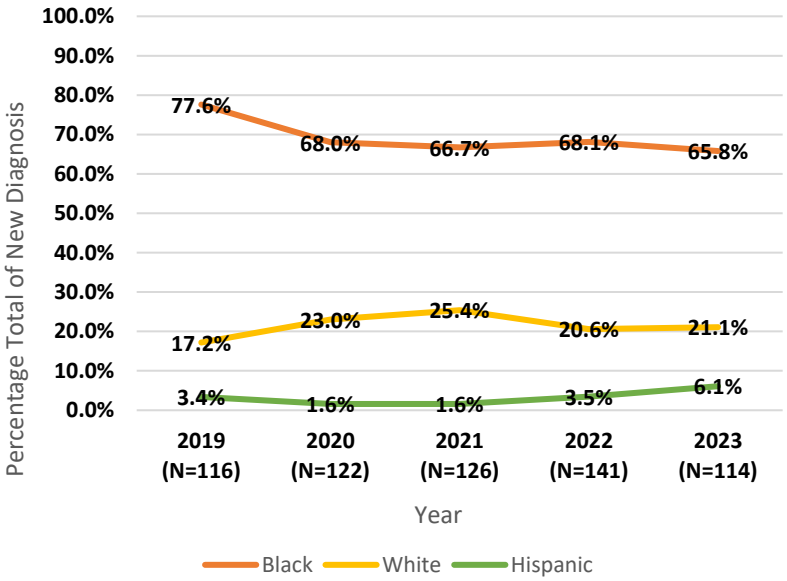
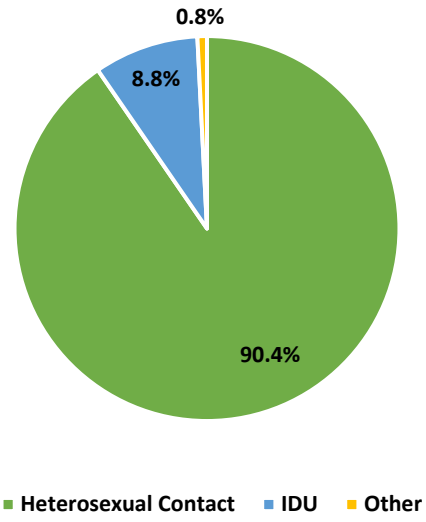


Table 12: New HIV Diagnosis among Adult/Adolescent Females Based on Sex at Birth by Transmission Category, 2023



AIDS At the Time of Diagnosis

Timely diagnosis is a critical determinant of individual and public health outcomes, as early detection enables prompt initiation of antiretroviral therapy (ART), reduces morbidity and mortality, and significantly decreases the likelihood of onward transmission. Delayed diagnosis, by contrast, is associated with advanced immunosuppression, higher healthcare costs, and diminished treatment efficacy. Structural factors, including limited access to testing services, stigma, and economic differences, remain major challenges to early testing, particularly in marginalized populations. Expanding routine opt-out screening in healthcare settings, increasing the availability of community-based and self-testing options, and strengthening public health outreach have been shown to improve early detection rates. Ultimately, timely HIV diagnosis functions not only as a clinical priority but also as a cornerstone of effective HIV prevention strategies.

Approximately 16% of people living with HIV in Alabama are unaware of their HIV diagnosis. While advances in treatment prevent progression to AIDS for many, late diagnosis remains a significant concern.

Among cases diagnosed at ages 25-34 years, 51% had a late HIV diagnosis, which was more than the proportion of late diagnosis among cases ≥45 years. These data point to the need for increased HIV testing among young adults.

Black African Americans had the highest proportion of late diagnosis in 2023 in Alabama, followed by Whites and then the Latino population.

Table 13: Percentage of Late Diagnosis, 2023

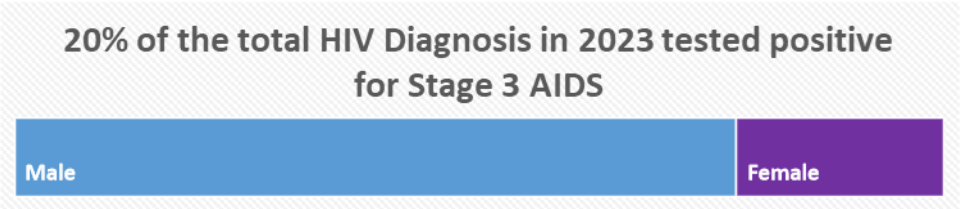


Table 14: Percentage Diagnosed, as Stage 3 AIDS based on Demographics, 2023

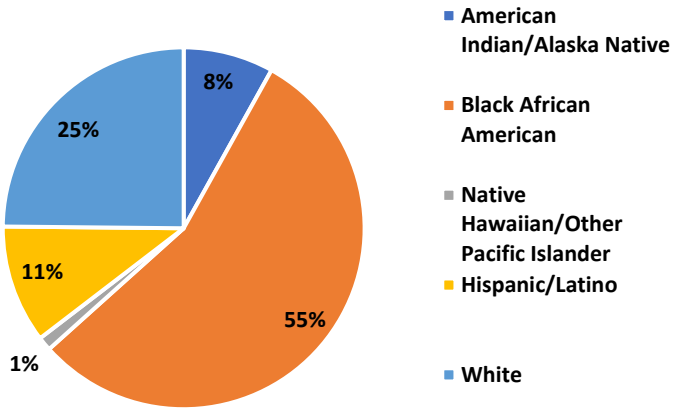
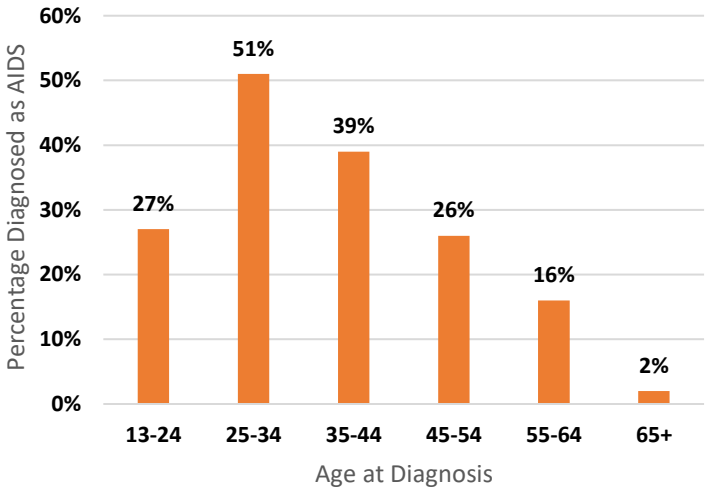
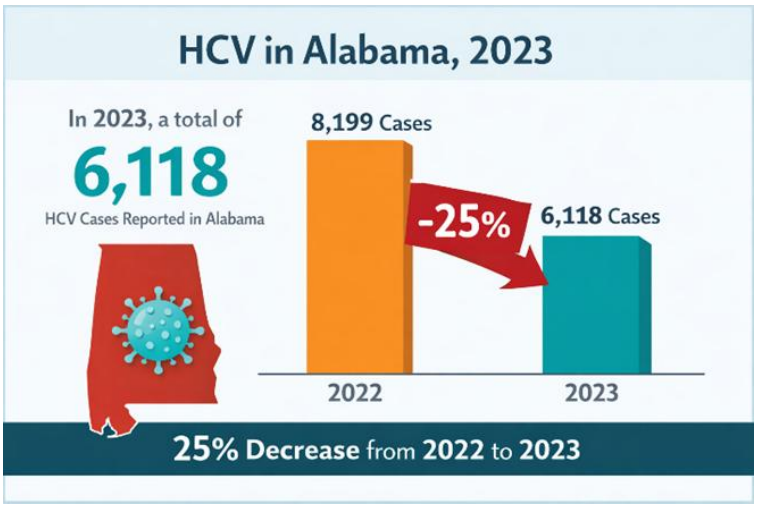


Table 15: Late Diagnosis by Age Group, 2023



Comorbidities

Figure 3: Hepatitis C Cases, 2023



Hepatitis C (HCV)

In 2023, a total of 6,118 people in Alabama were reported with HCV. This represents a 25% decrease (2,081) in HCV cases compared with the number reported in 2022.

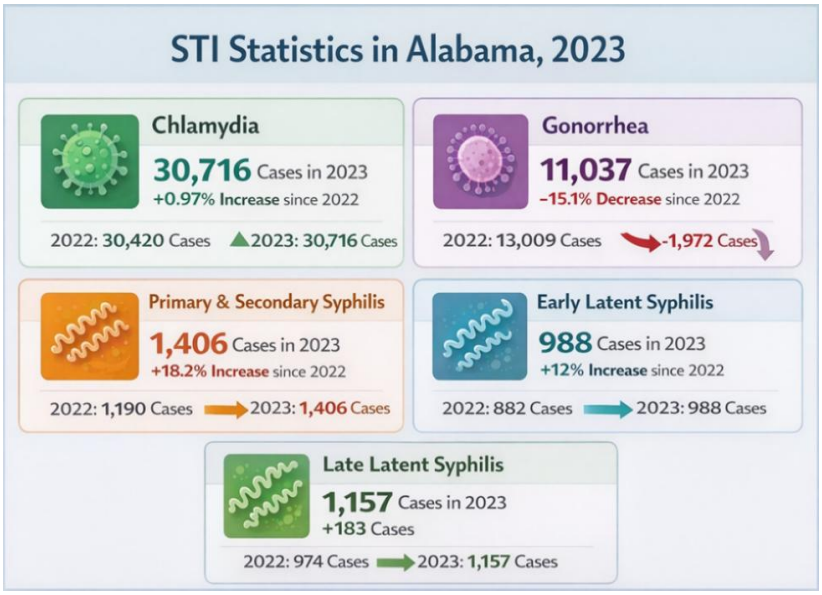
The incidence of HCV cases has been consistently higher among Whites than among any other racial or ethnic group. Forty-three percent of reported HCV cases had demographic markers as unknown.

The number of males diagnosed with HCV in 2023 (3,722, 58%) is higher than that of females (2,358, 36.7%). Five percent of cases reported their gender as "other".

Jefferson (1,306), Mobile (666), Montgomery (452), Madison (381), and Calhoun (228) counties reported the highest number of HCV cases in 2023.

From 2018 to 2023, male-to-male sexual contact was the most common risk factor for people with HIV/HCV coinfections (38.3%), followed by injection drug use (15.3%). People with HIV/HCV coinfection were mostly men (78%). Persons aged 30-34, 35-39, and 50-54 comprised 13.2%, 14.6%, and 13.3% of HIV/HCV cases. By demographics, African Americans (46.7%) and White people (32.3%) were most affected.

Sexually Transmitted Infections



Sexually Transmitted Infection surveillance data serve as a proxy indicator of behavior that could transmit HIV or other infections. Although a rise in incidence of sexually transmitted diseases does not unequivocally signify a concurrent increase in HIV infections, these surrogate indicators suggest a growing prevalence of unprotected sexual activity, which is a well-established risk factor for HIV transmission.

Figure 4: Sexually Transmitted Infections Cases, 2023

Chlamydia

In 2023, a total of 30,716 people in Alabama were reported to have chlamydia. This represents a 0.97% (296 cases) increase in chlamydia cases compared with the number of cases reported in 2022.

The incidence of chlamydia cases has been consistently higher among African Americans than any other racial or ethnic group, and 68.7% higher among females than males. In 2023, African Americans comprised approximately 27% of Alabama's population while experiencing 44% of cases, illustrating this significant variance.

In 2023, the number of chlamydia cases reported was highest among persons ages 15-19 and 20-24. Persons ages 15-19 and 20-24 accounted for 27.8% and 36.6% of the chlamydia cases reported in 2023, respectively.

Jefferson (5,685), Mobile (3,014), Montgomery (2,577), and Madison (2459) counties reported the highest number of chlamydia cases in 2023.

Gonorrhea

A total of 11,037 Alabama residents were reported with gonorrhea in 2023. This reflects a decrease from 2022 to 2023. In 2023, the national case rate for gonorrhea was 179.5 per 100,000. Alabama's 2023 gonorrhea case rate was 216.1 per 100,000.

In 2023, 6,026 cases were diagnosed among the African American population. Of the 6,026 reported gonorrhea cases, 3,051 had demographic information marked as "unknown".

The number of males (5,899 or 53.4%) diagnosed with gonorrhea in 2023 is higher than that of females (5,050 or 45.8%).

Persons aged 15-19, 20-24, and 25-29 accounted for 20.5%, 31.7%, and 18.7% of the gonorrhea cases reported in 2023, respectively.

Approximately 58% of the gonorrhea cases reported in 2023 occurred in Alabama's urban counties (Jefferson, Montgomery, Mobile, Madison, and Tuscaloosa). Twenty-one percent of gonorrhea cases reported in 2023 were residents of Jefferson County.

A total of 613 gonorrhea cases diagnosed in 2023 were co-infected with HIV. More than 68.5% of gonorrhea cases co-infected with HIV in 2023 were residents of Jefferson (193), Tuscaloosa (71), Montgomery (56), Mobile (51), and Madison (49) counties.

Primary & Secondary Syphilis

A total of 1,406 people in Alabama were reported with Primary and Secondary (P&S) Syphilis in 2023. This reflects an 18.2% (216) increase in P&S Syphilis incidence cases from 2022 to 2023. Alabama's 2023 P&S Syphilis case rate was 27.5 per 100,000.

In 2023, a total of 186 P&S Syphilis cases were co-infected with HIV.

African Americans continued to represent the most P&S Syphilis cases diagnosed among people in Alabama. African Americans accounted for 58% of the P&S cases diagnosed in 2023. Alabama's

Caucasian and multiracial populations accounted for 33.4% and 4.8% of P&S Syphilis cases in 2023.

The number of P&S cases has consistently been higher among males than among females. In 2023, a total of 939 males were diagnosed with P&S Syphilis compared to 467 females.

Persons aged 20-24, 25-29, and 30-34 comprised most P&S Syphilis cases reported between 2019 and 2023. Persons aged 25-29 reported a total of 266 P&S Syphilis cases in 2023.

Jefferson (280), Mobile (224), Montgomery (170), Madison (62), and Tuscaloosa (58) represented 56.4% of reported cases in 2023. Despite Jefferson County's larger population, Montgomery County had the highest case rate per 100,000, at 75.6.

Early Latent Syphilis

A total of 988 Alabama residents were reported with Early Latent Syphilis (EL) in 2023. This reflects a 12% increase in EL Syphilis cases from 2022 to 2023. Alabama's total EL Syphilis case rate was 19.3 per 100,000.

In 2023, a total of 25 cases of early latent syphilis were co-infected with HIV.

In 2023, African Americans accounted for 66% of the reported cases compared to Caucasians (26.4%) and Latinos (2.6%).

A total of 646 EL Syphilis cases were reported as males in 2023, compared to 342 cases reported as females.

Person aged 25-29 accounted for 21.9% of EL Syphilis cases reported in 2023.

Jefferson County reported the most cases (227) in 2023, followed by Montgomery (182), Tuscaloosa (85), Mobile (62), and Madison (51) counties. These counties accounted for nearly 61.4% of EL Syphilis cases reported in 2023. Twenty-three percent of the EL cases reported in 2023 were residents of Jefferson County.

Based on the number of EL Syphilis cases reported by counties, Montgomery (80.9), Tuscaloosa (35.8), and Jefferson (34.2) counties had the highest infection rates per 100,000 in 2023.

Late Latent Syphilis

A total of 1,157 residents were reported with Late Latent (Late) Syphilis in 2023. Alabama's 2023 Late Syphilis case rate was 22.6.

In 2023, a total of 134 cases of late syphilis were coinfected with HIV.

Over the past 5 years, the number of cases has been the highest among African Americans. In 2023, African Americans accounted for 59% of reported cases compared to Whites (31.5%), Multiracial (4.1%), and Latinos (3.8%).

The number of cases has consistently been higher among males than among females. In 2023, males accounted for 57.4% of reported Late Syphilis cases.

In 2023, persons aged 20-24, 25-24, 30-34, and 35-39 combined to account for 62.3% of Late Syphilis reported in Alabama. Persons aged 25-29 reported a total of 207 Late Syphilis cases in 2023.

Jefferson and Mobile counties reported the most cases (173) in 2023, followed by Montgomery (149), Tuscaloosa (57), Madison (41), and Limestone (36). These counties accounted for nearly 54.3% of Late Syphilis cases reported in 2023.

Based on the number of Late Syphilis cases reported by county, Montgomery (66.2), Mobile (42.0), and Houston (38.7) counties' rates of infection were the highest among Alabama counties in 2023.

HIV Prevention, Care, and Treatment Resource Inventory

As part of developing the Integrated HIV Prevention and Care Plan, a comprehensive resource inventory was conducted to assess the availability, distribution, and capacity of HIV prevention, care, and treatment services across Alabama.

Provider	Funding Sources Awarded Through ADPH	Additional Funding Sources Awarded Directly to Subrecipient	Services Provided	Priority Population	Diagnose	Prevent	Treat	Respond
AIDS Action Coalition (Thrive)	CDC EHE, CDC Prevention, HRSA EHE, RWHAP Part B	RWHAP Part C, SAMHSA, VOCA, NGAGE, FQ330, BHSE	Early Intervention Services (EIS), Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Housing, Linguistic Services, Medical Case Management, including Treatment Adherence Services, Medical Transportation, Behavioral Health Services, Non-Medical Case Management Services, Oral Health Care, Outpatient/Ambulatory Health Services, PrEP, HIV and Hep C Prevention and Testing	All populations with a strong emphasis on people of color, those vulnerable to HIV acquisition, and those living with HIV	✓	✓	✓	✓
AIDS Alabama South	CDC Prevention, HRSA EHE, RWHAP Part B	HOPWA, State Legislature Funding, 340B	Early Intervention Services (EIS), Emergency Financial Assistance, Food Bank/Home Delivered Meals, Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Medical Transportation, Behavioral Health Services, Non-Medical Case Management Services, Oral Health Care, Other Professional Services, Outpatient/Ambulatory Health Services, Outreach Services, Psychosocial Support	All populations with a heavy focus on SGM and People of Color	✓	✓	✓	✓

			Services, Referral for Health Care and Support Services, Substance Abuse Outpatient Care, Hep C, PrEP, HIV/STI Testing					
AIDS Alabama, Inc.	CDC EHE, CDC Prevention, RWHAP Part B		Administrative or technical support, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Housing, Linguistic Services, Medical Case Management, including Treatment Adherence Services, Medical Transportation, Behavioral Health Services, Non-Medical Case Management Services, Outpatient/Ambulatory Health Services, Outreach Services, Psychosocial Support Services, Substance Abuse Outpatient Care		✓	✓	✓	✓
Alabama Coalition Against Rape (ACAR)	CDC EHE		HIV Testing, Education, Condom Distribution		✓	✓		✓
Aletheia House	RWHAP Part B		Emergency Financial Assistance, Health Education/Risk Reduction, Housing, Medical Transportation, Non-Medical Case Management Services, Substance Abuse Outpatient Care		✓		✓	
Birmingham AIDS Outreach (BAO)	HRSA EHE, CDC Prevention, RWHAP Part B		Early Intervention Services (EIS), Emergency Financial Assistance, Ending the HIV Epidemic Initiative Services, Health Education/Risk Reduction, Medical Case Management, including Treatment Adherence Services, Medical Transportation, Non-Medical Case Management Services, Outreach Services, Referral for Health Care		✓	✓	✓	✓

			and Support Services, Food Bank/Home Delivered Meals, Medical Nutrition Therapy, Other Professional Services, Psychosocial Support Services					
Cahaba Medical Care Foundation	RWHAP Part B		Emergency Financial Assistance, Food Bank/Home Delivered Meals, Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Medical Transportation, Behavioral Health Services, Non-Medical Case Management Services, Oral Health Care, Outpatient/Ambulatory Health Services, Substance Abuse Outpatient Care				✓	
Centro de Acceso para Latinos de Alabama (CALA)	HRSA EHE		Emergency Financial Assistance, Medical Case Management, Transportation, Behavioral Health Services, Policy Advocacy, Peer Support, Legal, Interpretation and Translation, Domestic Violence, Substance Abuse Services, HIV Health and Education	Latinos			✓	✓
Central Al. Alliance, Resource and Advocacy Center (CAARAC)	CDC Prevention		Education and Outreach, HIV/HCV Testing and Prevention, Advocacy and Support		✓	✓		
East Alabama Health Services, LLC (Unity Wellness)	CDC Prevention, RWHAP Part B	RWHAP C, HOPWA	Early Intervention Services (EIS), Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Case Management, including Treatment Adherence Services, Medical Transportation, Oral Health Care, Outpatient/Ambulatory Health Services, HIV	Male-to-Male Sexual Contact (MMSC), Black Women, Transgender Women, Youth (18-24)	✓	✓	✓	

			Counseling and Testing, HIV Primary Medical Care, Prevention and Outreach					
Empowered Health Equity Al. (EHE Al)	CDC Prevention		HIV Education and Testing	College and University students	✓	✓		
Family Counseling Center of Mobile (Lifelines)	CDC EHE		Non-Medical Case Management Services, Outreach Services, Psychosocial Support Services, Referral for Health Care and Support Services	Cis gender Black women, sexual assault survivors, PLWH who are out of care, HBCC campus/students	✓	✓	✓	✓
Franklin Primary Health Center	RWHAP Part B		Early Intervention Services (EIS), Emergency Financial Assistance, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Medical Transportation, Behavioral Health Services, Oral Health Care, Outpatient/Ambulatory Health Services, Substance Abuse Outpatient Care	All populations			✓	
Health Service Center, Inc.	CDC EHE, HRSA EHE, CDC Prevention, RWHAP Part B	CDC, RWHAP C, RWHAP D, HUD, HOPWA, Legislative Service Dollars	Emergency Financial Assistance, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Non-Medical Case Management Services, Oral Health Care, Outpatient/Ambulatory Health Services, Food Bank/Home Delivered Meals, Medical Transportation, Outreach Services, Psychosocial Support Services, HIV/STI Testing and Treatment, PrEP Services, Substance Use Prevention and Treatment	PLWH, People vulnerable to HIV acquisition, Drug Court Referrals, IDU, Individuals experiencing homelessness, Individuals with behavioral health needs	✓	✓	✓	✓
Mental Health Association	CDC EHE		HIV Prevention and Education	Individuals vulnerable to HIV	✓	✓		✓

of Morgan County				acquisition for HIV, including IDU				
Mobile County Health Department	Hepatitis C, RWHAP Part B		Early Intervention Services (EIS), Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Linguistic Services, Medical Case Management, including Treatment Adherence Services, Non-Medical Case Management Services, Oral Health Care, Outpatient/Ambulatory Health Services, Outreach Services, Substance Abuse Outpatient Care		✓	✓	✓	
Selma Air, Inc.	CDC Prevention, RWHAP Part B	HOPWA, Alabama Legislative Services, and Prevention Education	Emergency Financial Assistance, Food Bank/Home Delivered Meals, Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Medical Transportation, Behavioral Health Counseling, Non-Medical Case Management Services, Oral Health Care, Outreach Services, Referral for Health Care and Support Services, Substance Abuse Outpatient Counseling, HIV Testing and Education, Peer Support Services	PWH and Persons vulnerable to HIV acquisition	✓	✓	✓	
University of Alabama at Birmingham – Emergency Department	CDC EHE, HRSA EHE		Universal routine opt-out HIV and Hep C testing, Outreach Services	Insured, Underinsured, and Uninsured, including patients with a history of substance use disorders (including IDUs), Blacks, and other			✓	✓

				minority populations				
University of Alabama at Birmingham - Family Clinic	CDC EHE, CDC Prevention, HRSA EHE, RWHAP Part B	RWHAP D	Early Intervention Services (EIS), Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Linguistic Services, Medical Case Management, including Treatment Adherence Services, Medical Transportation, Behavioral Health Services, Non-Medical Case Management Services, Oral Health Care, Other Professional Services, Outpatient/Ambulatory Health Services, Outreach Services, PrEP	Women, pregnant women, infants, children, and young adult males up to the age of 25, PrEP services opened to all with a focus on ages 15-26	✓	✓	✓	✓
West Alabama AIDS Outreach (Five Horizon Health Service)	CDC EHE, CDC Prevention, HRSA EHE, RWHAP Part B	RWHAP Part C, RWHAP Part D, SAMHSA, HOPWA	Early Intervention Services (EIS), Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Case Management, including Treatment Adherence Services, Medical Transportation, Non-Medical Case Management Services, Outpatient/Ambulatory Health Services, Ending the HIV Epidemic Initiative Services, Health Education/Risk Reduction, Outreach Services, PrEP, PEP, STI Education, Testing, & Treatment, Behavioral Health Services	MMSC, AA Women, Transgender, Youth Aged 13-24, IDU, justice-involved People	✓	✓	✓	✓
Whatley Health Services, Inc.	CDC Prevention, RWHAP Part B	RWHAP Part C, Bureau of Primary Health Care-PrEP	Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Linguistic Services, Medical Nutrition Therapy, Medical Transportation, Non-Medical Case	All populations	✓	✓	✓	

			Management Services, Oral Health Care, Outpatient/Ambulatory Health Services, Referral for Health Care and Support Services, PrEP Services, Hepatitis C Prevention, Care and Treatment Services					
Jefferson Co. Health Department			HIV Testing and Education, Sexual Health Clinic, Hepatitis C Testing and Treatment, PrEP & PEP Clinic, Dental Clinic	All populations	✓	✓	✓	
UAB 1917 Clinic		RWHAP C	Primary HIV Care, Women's HIV Clinic, HIV and STI Testing, PrEP, Behavioral Health & Counseling, Pharmacy Services, Social Services, Research Opportunities, Specialty Clinic, Dental	PWH, Patients in need of specialty care, and areas with limited access to services	✓	✓	✓	
University of South Alabama (Mobile)		RWHAP D	Preventive Care, Specialty Care, Rehabilitation, Primary Care, Core Medical Services, HIV Testing, Support Services, Student Services, Research Opportunities	Women, pregnant women, infants, children, PWH, areas with limited access to services, and patients with complex conditions	✓	✓	✓	

Collaborative Mapping: Building Alabama's HIV Resource Inventory

To develop the resource inventory, ADPH-funded recipients verified their funding allocations, subrecipient information, priority populations, and contracted services. This process ensured accurate documentation of prevention, care, and treatment capacity across the state.

The development of the resource inventory strengthened understanding of the Alabama HIV continuum by identifying existing system strengths, service duplication, geographic gaps, and gaps in prevention, linkage, retention, and viral suppression efforts.

To ensure a fully integrated and coordinated system of care, the resource inventory also includes providers who do not receive direct funding from ADPH but contribute significantly to HIV prevention and care outcomes.

Mechanisms to support collaboration with non-ADPH-funded providers include:

- Engagement in provider networks and advisory bodies,
- Involvement in the statewide AQMG and APCG, and
- Identified champion or point of contact to serve as a liaison for information sharing.

Collaboration among stakeholders remains critical to maximizing resources and improving efficiency in serving PWH. As subrecipients and partner organizations continue to enhance high-quality, coordinated prevention, care, and treatment services, intentional collaboration will become increasingly important.

Providing comprehensive services that fully address each stage of the HIV continuum, from diagnosis to viral suppression, requires shared accountability, integrated service delivery models, and sustained cross-system communication.

The resource inventory serves not only as a catalog of services but as a framework for strengthening partnerships, aligning funding streams, and advancing universal access to prevention and care services statewide.

HIV Resource Inventory: Strengths and Gaps Assessment

The HIV Resource Inventory demonstrates a broad network of providers delivering prevention, care, and supportive services across Alabama. The inventory includes ASOs, federally qualified health centers, academic medical centers, and local health departments that collectively contribute to the statewide HIV response. These organizations provide services across the HIV continuum, including testing and diagnosis, prevention services such as PrEP and risk reduction education, HIV medical care, and a range of supportive services designed to improve health outcomes and retention in care.

A key strength of the HIV service landscape is the availability of comprehensive, wraparound services provided through multiple funding streams, including the Ryan White HIV/AIDS Program (Parts B, C, and D), CDC HIV Prevention and Ending the HIV Epidemic initiatives, and other federal and state funding sources. Many providers offer integrated services, including early intervention, medical and non-medical case management, behavioral health services, transportation, housing assistance, food support, and treatment adherence services. These supports address social and structural challenges that often affect engagement in care and treatment outcomes for people living with HIV. The inventory also reflects a strong network of providers with established

relationships in priority groups. This stakeholder presence supports context-aware outreach, prevention education, and linkage to care.

Despite these strengths, the inventory highlights several important gaps in the HIV service landscape. The geographic distribution of services remains uneven, with many providers concentrated in urban centers such as Birmingham and Mobile, as well as in other higher-population areas. Smaller counties often have fewer local HIV-specific services and rely on regional providers for testing, prevention, and treatment. This geographic infrastructure may contribute to delays in diagnosis, transportation challenges, and reduced access to prevention services. Strengthening service access in rural and under-resourced areas, including through mobile services, telehealth, and partnerships with county health departments and non-funded providers, may help address these gaps.

The inventory also suggests underutilization of HIV prevention tools, particularly PrEP and harm reduction services. While several organizations offer PrEP services, access is not consistently available across all prevention providers, and the quality of navigation services to support PrEP uptake varies. Additionally, harm reduction strategies targeting people who inject drugs remain limited, in part due to policy challenges that restrict syringe service programs, which do not allow the distribution or collection of needles and syringes for individuals who inject drugs. Expanding prevention navigation, increasing provider capacity to prescribe PrEP, and strengthening partnerships with organizations serving individuals with substance use disorders could help increase the reach of these prevention tools.

Finally, the assessment highlights opportunities to strengthen the system's ability to respond to emerging HIV clusters and outbreaks. While many organizations provide testing, outreach, and linkage services, fewer programs explicitly support coordinated outbreak detection and rapid response activities. Strengthening collaboration between public health surveillance teams, clinical providers, and ASOs can improve the timely identification of transmission clusters and ensure rapid deployment of testing, prevention, and treatment services in affected counties.

Overall, the HIV Resource Inventory reflects a strong network of providers supporting the HIV prevention and care continuum in Alabama. However, reducing regional gaps in health outcomes, expanding prevention tool utilization, and strengthening coordinated response capacity will be critical to improving universal access to services and advancing statewide efforts to reduce new HIV infections and improve health outcomes for people living with HIV.

Cross-Program Collaboration to Address STI Transmission

In 2023, no molecular-identified HIV transmission clusters were reported in Alabama. However, concerns regarding elevated syphilis transmission within the Alabama Department of Corrections (ADOC) system prompted increased public health attention. In response to reports of a potential outbreak, ADPH implemented a coordinated screening initiative across multiple state correctional facilities in early to mid-2024, including Staton, Limestone, William E. Donaldson, and Ventress.

This response was led by ADPH's Division of Sexually Transmitted Disease (STD), in partnership with the Office of HIV Prevention and Care, staff from ASOs, and YesCare nursing staff.

Multidisciplinary teams conducted on-site syphilis and HIV screening using rapid Chembio diagnostic test kits. Before each screening event, participating staff coordinated logistics, secured access to the facility, and reviewed screening protocols to ensure efficient implementation in the correctional setting.

Individuals with reactive HIV screening results received confirmatory testing, and those newly diagnosed were promptly linked to HIV medical care within the ADOC system to support timely initiation of treatment. Persons newly diagnosed with syphilis were treated on site by YesCare clinical staff in accordance with CDC guidelines, including administration of benzathine penicillin G (Bicillin). This coordinated response reflects ongoing efforts to strengthen surveillance, testing, treatment, and linkage to care within congregate settings to mitigate STI transmission and support continuity of HIV prevention and care services.

Partner Services

A free and confidential program provided by the health departments to support individuals diagnosed with sexually transmitted infections (STIs). The program helps notify sexual or needle-sharing partners of possible exposure in a private and anonymous manner. It also offers testing, treatment referrals, and counseling to both the diagnosed individual and their partners to help interrupt ongoing transmission.

The goal of partner services is to reduce the spread of infection, ensure timely testing and treatment for exposed partners, and strengthen linkage to prevention and care services.

Safety remains the top priority for ADOC staff; however, strong cross-collaboration efforts have enhanced STI and HIV screening within correctional facilities to ensure continuity of prevention and care services. Through coordinated partnerships, persons experiencing incarceration who have a reactive HIV test receive partner services and risk-reduction counseling delivered by Disease Intervention Specialists (DIS). This collaborative effort helps ensure timely testing, linkage to care, and appropriate follow-up while maintaining facility security protocols. In addition, HIV District Managers conduct routine education and testing (HIV and Hep C) initiatives in local county jails, with support from local ASOs, CBOs, and DIS staff, to expand early detection, prevention awareness, and linkage to treatment services upon release.

Maximizing the Quality of Health and Support Services Available to People Vulnerable to HIV Acquisition

The Alabama Department of Public Health is committed to protecting, promoting, and improving the health of Alabama's residents through a comprehensive, statewide public health infrastructure. Each county in Alabama is served by a county health department that delivers sexually transmitted disease (STD) services, including screening, counseling, treatment, partner services, targeted outreach to populations of focus, and public education on prevention strategies.

HIV intervention services provided through county health departments include HIV screening, counseling, partner services, and referral to care for individuals diagnosed with or vulnerable to HIV acquisition. These services incorporate pre- and post-test counseling and support timely linkage to medical care for individuals living with HIV to facilitate treatment initiation, viral suppression, and long-term health maintenance.

To reduce stigma, address transportation challenges, and encourage proactive engagement in sexual health, ADPH offers at-home specimen collection kits in partnership with imaware, with laboratory testing for HIV, Syphilis, Chlamydia, and Gonorrhea through a mail-based program.

These kits are available to all Alabama residents and select individuals enrolled in pre-exposure prophylaxis (PrEP) care who are eligible to request one test kit every 3 months. The at-home testing program expands access to confidential, convenient testing, supports early diagnosis, and reduces reliance on traditional clinic-based services, thereby contributing to decreased transmission and improved health outcomes statewide.

> *"I used the mail-in STI testing service before and had a good experience". - Person vulnerable to HIV acquisition Focus Group Participant*

ADPH also offers Fast Track Sexual Health Testing, which provides rapid, free, and confidential STI screening for asymptomatic individuals. Services include screening for chlamydia, gonorrhea, syphilis, and HIV. Clients may access testing through walk-in visits or scheduled appointments, enabling same-day services without a clinical provider. Test results are available through a secure patient portal, enhancing accessibility and efficiency. Expedited sexual health testing is currently offered at select county health departments, with plans to expand availability statewide.

Condoms remain a critical component of HIV prevention. When used consistently and correctly, condoms are highly effective in preventing HIV transmission and are the only prevention method that also reduces the risk of other STIs and unintended pregnancy. In response to rising HIV and STI rates and documented low condom utilization, ADPH maintains statewide condom distribution efforts to ensure continued access to free safer sex supplies. These efforts are complemented by ongoing education to increase awareness of condom efficacy and correct use.



Free condoms and safer sex supplies are widely available through ASOs, local partners, and direct-to-individual distribution initiatives across Alabama, supporting comprehensive, public HIV and STI prevention strategies.[2]

The Office of HIV Prevention and Care and the STD Division collaborate closely to enhance the quality, accessibility, and effectiveness of health and support services for individuals at increased vulnerability to HIV and other STIs. This coordinated, integrated approach addresses structural and social challenges to care, including financial constraints, limited access to services, transportation challenges, and stigma, through client-centered service delivery models designed to improve fairness in health outcomes.

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[2] Innovative Prevention Strategy: One of the subrecipients of ADPH has implemented a harm reduction vending machine to provide residents with 24/7 access to prevention supplies. Machine may include items such as condoms, lubricants, fentanyl test strips, naloxone, and other harm reduction materials.

Disclaimer: This image is a conceptual illustration used for presentation purposes and does not represent the actual vending machine or location.

HIV/AIDS Knowledge and Practice: Community Survey

In Alabama, where HIV prevalence remains disproportionately high among certain populations, assessing public knowledge is essential to designing responsive, data-driven prevention strategies. Understanding how residents receive HIV-related information, what they believe about transmission and prevention, and where knowledge gaps persist directly informs outreach, stigma-reduction, and service linkage efforts.

The HIV/AIDS Knowledge and Practice: Community Survey was developed as a supplemental instrument to the statewide HIV Needs Assessment. While the Needs Assessment focused on service access, care impediments, and system-level gaps among people with HIV and providers, the Community Survey was designed to assess general population knowledge, prevention literacy, and information pathways among lay members. Specifically, it sought to evaluate how individuals obtain HIV-related information, their understanding of prevention methods (including testing, PrEP, treatment as prevention, and condom use), and their perceptions of risk.

Survey findings provide an important baseline for Alabama's Integrated HIV Prevention and Care Plan. Preliminary results indicate that, while traditional information channels, such as the Alabama Department of Public Health, continue to reach segments of the population, substantial awareness and knowledge gaps remain. These results provide a baseline for the HIV Integrated Plan and highlight the need for expanded HIV education.

However, implementing the Integrated Plan engagement activities required significant strategic redirection. During the initial Needs Assessment phase, response rates were underwhelming despite planned outreach efforts. Because the Needs Assessment was identified as the foundational data source for resource allocation, priority setting, and strategic planning, low participation posed a risk to the empirical integrity and long-term viability of the Integrated Plan.

Given these constraints, the HIV Governing Body conducted a rapid reassessment of concurrent engagement activities. Although the Community Survey provided valuable supplemental insight into general prevention knowledge, its activities were formally suspended to preserve focus, strengthen data quality, and ensure the long-term integrity of the HIV Integrated Plan.

This decision reflects a strategic prioritization approach grounded in sustainability and methodological rigor. By redirecting resources to strengthen participation in the Needs Assessment, the planning body ensured that the Integrated Plan would be anchored in comprehensive, representative data regarding service needs, care gaps, and structural challenges. At the same time, data already collected through the Community Survey remains valuable as a preliminary baseline for HIV prevention literacy in Alabama and will inform future phases of health communication strategy development.

Collectively, these efforts demonstrate a responsive and adaptive planning process that balances stakeholder engagement, data integrity, and strategic resource allocation to advance Alabama's goals of reducing new HIV infections, improving viral suppression, and closing the gap across populations.

Survey Overview

The Community Knowledge Survey was conducted between August and October 2025 via a REDCap QR code and paper format. A total of 288 respondents participated, with a 95% survey completion rate (n=274). Surveys were primarily administered through health fairs and outreach events.

Participant's Demographics

The respondent population reflects priority groups disproportionately impacted by HIV in Alabama. Most respondents identified as Black or African American (89%), with 67% female and 33% male. Notably, 66% of respondents were between 16 and 24, indicating substantial engagement among youth and young adults.

HIV Education Topics

Overall, findings indicate uneven coverage of HIV education topics, with higher emphasis on basic HIV knowledge and prevention resources, and substantially lower coverage of biomedical prevention, treatment literacy, and status-related counseling.

HIV/AIDS Knowledge Survey Outreach
Selma Health Fair & Back to School Bash w/ Kappa Alpha Psi Fraternity
ASU Healthy Welcome Back
Talladega Fall STI/HIV Testing Event
Stillman Fall STI/HIV Testing Event
Stillman Night Out
University of Alabama Tuscaloosa Fall Health Fair

Foundational knowledge is relatively strong, with nearly two-thirds of respondents reporting education on HIV transmission and prevention. Resource-based education (e.g., free condoms, information on the importance of testing) was moderately common, suggesting effective dissemination of traditional prevention messaging. Biomedical prevention and treatment literacy remains limited. Less than one-third of respondents reported receiving education on PrEP, PEP, or viral load suppression, and fewer than one in four respondents were informed about U=U, despite its central role in stigma reduction and treatment engagement. Disclosure counseling was reported by only 26.7% of respondents, highlighting a gap in psychosocial and supportive education for people living with or vulnerable to HIV acquisition for HIV. Notably, over one-fifth of respondents (22.6%) reported receiving no HIV education at all in the past year, indicating persistent access and outreach gaps.

These findings suggest that HIV education efforts remain skewed toward general awareness, while critical advances in HIV prevention and treatment science are not consistently communicated. Expanding education on PrEP, PEP, viral suppression, and U=U is essential to:

- Improve uptake of biomedical prevention strategies,
- Reduce HIV-related stigma and,
- Support timely diagnosis, linkage to care, and sustained viral suppression.

Targeted education strategies are needed to ensure comprehensive HIV knowledge reaches populations most impacted by HIV and those currently neglected by existing outreach efforts.

Biomedical Prevention: Awareness and Willingness

Over half of respondents (51.6%) reported no awareness of PrEP or PEP, indicating a critical knowledge gap in prevention. This directly supports the Integrated Plan's priorities to:

- Increase PrEP and PEP education

- Strengthen provider and stakeholder prevention meetings
- Expand linkage to biomedical prevention, particularly among populations with higher disease burden.

Sixty-two percent (62%) of respondents reported that they would not know how to obtain PEP if exposed to a STI. Given the time-sensitive nature of PEP initiation (within 72 hours of exposure), this lack of awareness represents a critical system-level prevention vulnerability. The findings underscore the need for targeted education campaigns in emergency departments, urgent care settings, and public spaces to increase awareness of rapid-access prevention options.

Survey responses indicate moderate to high levels of openness to PrEP, accompanied by substantial information gaps:

- 26% indicated they would take PrEP.
- 16% responded “maybe.”
- 26% reported they need more information.
- 32% indicated they would not take PrEP.

Overall, willingness to take PrEP reflects both opportunity and challenge. While many respondents express openness to PrEP, persistent hesitancy stemming from knowledge gaps, stigma, and limited access indicates the need for more robust, integrated PrEP education and navigation strategies. Addressing these factors is essential to achieving HIV Integrated Plan targets for reducing new HIV infections.

The Community Survey findings provide critical qualitative and quantitative insights into existing gaps in prevention awareness. They will directly inform measurable objectives, targeted interventions, and impact-oriented strategies within the HIV Integrated Plan.

HIV Needs Assessment

Assessing Needs, Shaping Solutions

The HIV Needs Assessment used a comprehensive mixed-methods approach to assess HIV prevention, care, and treatment needs across Alabama. The process was designed to align with the federal planning requirements and public health practice, while centering the perspectives of individuals disproportionately impacted by HIV.

Assessment Framework and Planning Process

The assessment was developed to inform the 2027–2031 Alabama HIV Prevention and Care Integrated Plan. An iterative planning process began with a review of epidemiological surveillance data, prior statewide needs assessments, program reports, federal guidance, and an established contractual partnership with UAB-SOPH to conduct the HIV Needs Assessment.

This review informed the identification of populations of focus and key focus areas, including HIV prevention, testing, linkage to care, retention in care, treatment adherence, and supportive services.

Input from state and local HIV program staff, HIV network partners, and subject-matter experts further refined the framework to ensure responsiveness to current service-delivery contexts and emerging challenges.

Data Collection Methods

A mixed-methods design was employed to capture both quantitative and qualitative perspectives.

Quantitative Data:

Structured surveys were developed for three stakeholder groups:

- People with HIV
- Individuals vulnerable to HIV acquisition
- Direct care providers

Surveys assessed service utilization, unmet needs, care impediments, system gaps, and recommendations for improvement. Instruments incorporated validated measures and were adapted to ensure regional relevance within Alabama. Surveys were available in electronic and paper formats and offered in both English and Spanish to enhance accessibility.

Qualitative Data:

Focus groups and facilitated discussions were conducted to gain deeper insight into lived experiences, structural, and service delivery challenges. These discussions complemented survey findings by providing contextual detail and capturing nuanced perspectives not fully reflected in quantitative data.



Figure 5: HIV Needs Assessment Timeline

Stakeholder Engagement and Outreach

Broad stakeholder engagement and outreach were central to the assessment strategy. Partnerships with District-level County Health Departments, ASOs, CBOs, District HIV Managers, and HREP were leveraged to reach PWH, individuals vulnerable to HIV acquisition, including those traditionally neglected in planning processes.

Data from multiple sources were triangulated to identify patterns and priority needs across the prevention and care service sequence. This integrated analysis strengthened validity and generated actionable insights to guide priority setting, resource allocation, and strategic planning.

Limitations and Engagement Challenges

Despite multiple recruitment strategies, participation from several priority populations remained limited. Outreach efforts included direct invitations, collaboration with ASOs and CBOs, and focused engagement of individuals with lived experience; however, response rates were lower than anticipated.

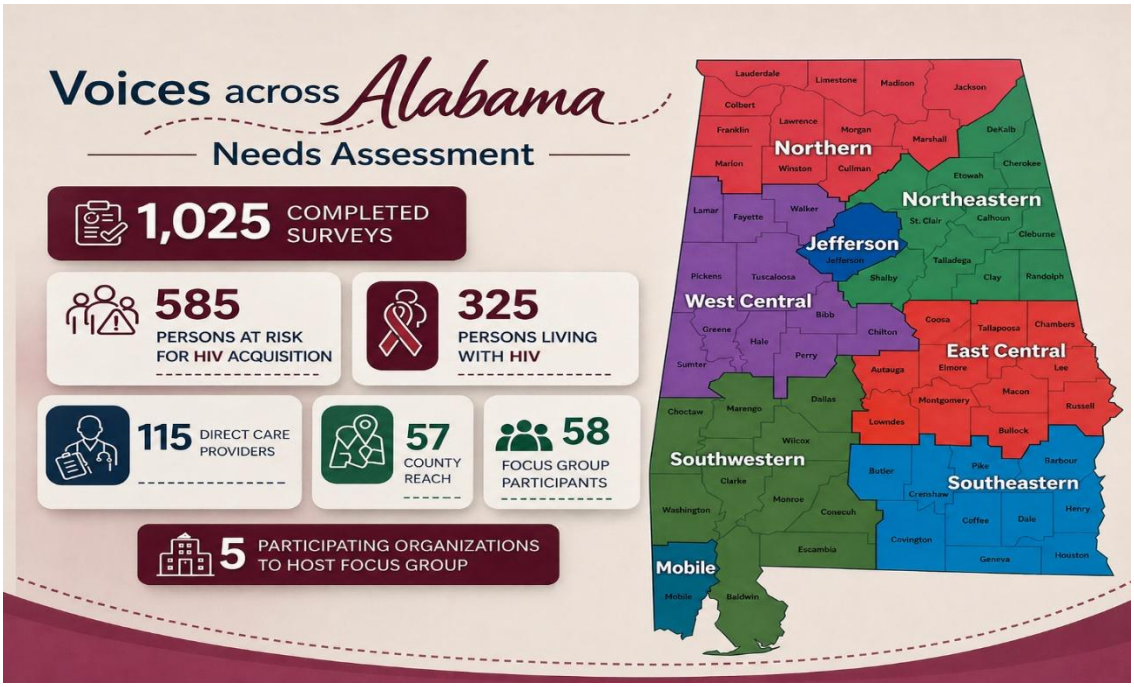
Some stakeholders declined to participate due to insufficient monetary incentives relative to the requested time commitment. Efforts to engage tribal organizations and Indian Health Service-affiliated groups were unsuccessful, as these entities did not respond to outreach or were unable to participate during the assessment period.

The limited representation of these populations constitutes a significant limitation, as it constrains the participation of perspectives essential to understanding challenges across the HIV prevention and care continuum. These challenges highlight the need for strengthened responsive engagement strategies, enhanced compensation practices, and sustained relationship building with tribal and HIV networks to ensure future assessments more fully reflect the voices of those most impacted by HIV. Furthermore, these insights will shape actionable strategies designed to strengthen and guide future HIV prevention and care initiatives.

Needs Assessment Snapshot: Key Findings

Findings from surveys and focus groups across people living with HIV, individuals vulnerable to HIV acquisition, and providers highlight critical gaps and opportunities across the HIV prevention and care continuum in Alabama. Participants consistently emphasized the importance of convenient testing, comprehensive prevention services, rapid linkage to care, and sustained support for treatment adherence and viral suppression. The insights reflect both individual and structural challenges affecting engagement with services. The following summary outlines key service needs and challenges identified to inform targeted, data-driven strategies.

Figure 6: HIV Needs Assessment Completion Results



HIV TESTING SERVICES:

Services Needed for HIV Testing Access & Staying Negative

- Routine, convenient testing options (e.g., community-based, mobile, walk-in, same-day services)
- Affordable or free HIV testing services
- Transportation support to improve access
- Confidential, stigma-free testing environments
- Contextual awareness of care from trusted providers
- Increased awareness of where and how to access services
- Expanded access to prevention services (PrEP education, navigation, and access)
- Access to primary care and preventive health services
- Pharmacy and medication access for prevention (e.g., PrEP)
- Comprehensive sexual health education
- Peer-led outreach and support
- Telehealth options to increase access

Rapid Linkage to HIV Care After Positive Diagnosis

- Immediate case management and care navigation (highly utilized and critical)
- Peer navigation and support from individuals with lived experience
- Clear referral pathways and improved coordination across providers
- Timely appointments and reduced wait times for treatment initiation
- Transportation and logistical support to attend appointments
- Follow-up systems (e.g., reminders, outreach) to support engagement and re-engagement

HIV CARE AND TREATMENT ISSUES:

Services for Maintaining Care & Achieving Viral Suppression

- Medical care
- Behavioral health counseling and psychological support
- Outpatient and peer-based substance use services
- Food assistance
- Non-medical case management
- Emergency financial assistance
- Housing support
- Transportation

Retention & Re-engagement Factors

- Engagement and retention improve when individuals feel supported and ready
- Access to trusted support systems for stress management and emotional well-being
- Access to trusted providers increases retention
- Outreach and follow-up efforts facilitate re-entry into care
    - Connection to a case manager

    - Connection to a person with lived experience
- Appointment reminders

CHALLENGES TO ACCESS:

HIV Testing Hindrance

- Stigma and fear of judgment
- Limited awareness of available services
- Concerns about maintaining confidentiality
- Competing priorities (e.g., work, time constraints)

Challenges with State Laws and Regulations

- Insurance coverage gaps, including a lack of Medicaid expansion
- Confusion around program eligibility and enrollment processes
- Administrative complexity in accessing services
- Funding limitations and instability affecting service availability
- Immigration-related policies/immigration status can affect health outcomes, which have broader public health implications

HIV Prevention, Care, and Treatment Access Issues

Structural Challenges

- Transportation
- Cost of care and services
- Housing instability and food insecurity
- Workforce shortages and service capacity limitations
- Disconnect between HIV awareness and actionable prevention steps
- Immigration-related consequences (e.g., fear of enforcement) discourage individuals and families from enrolling in coverage and/or accessing healthcare services

System-Level Gaps

- Poor coordination between providers and agencies
- Limited integration of prevention and care into routine healthcare
- Inconsistent information about available services

Social & Individual Challenges

- Stigma and judgment
- Behavioral health challenges
- Fear of disclosure
- Linguistic gaps, especially for the Latino population

Transforming Community Insight into Strategic Action

Findings from the statewide surveys and focus groups highlighted critical gaps and opportunities across HIV prevention, care, and support services. These insights reflect the lived experiences of people with HIV, individuals vulnerable to HIV acquisition, and providers across Alabama, underscoring the need for accessible, coordinated, and responsive systems of care.

The priorities identified through community engagement closely mirrored trends discussed with stakeholders. Together, these findings provided a comprehensive understanding of the challenges and opportunities facing Alabama's HIV system of care and directly informed the Focus Areas for Action. By integrating quantitative data with community perspectives, the planning process ensured that strategic priorities were both data-driven and responsive to the needs of those most affected by HIV.

Ending the HIV epidemic in Alabama requires more than clinical care alone. It demands a comprehensive, person-centered approach that integrates prevention, treatment, behavioral health, and supportive services while fostering collaboration, building trust, and strengthening systems that promote fair health outcomes for individuals and groups affected by HIV.

Actions Taken

Response Activities: HIV Needs Assessment Interventions

1. Conducted in-person and virtual meetings with staff from multiple clinics to encourage survey participation and strengthen engagement efforts.
2. Initially launched the HIV Needs Assessment survey in electronic format only. Following low response rates and stakeholder feedback, paper-based surveys were added to improve accessibility and increase participation.
3. Conducted district-level visits to meet with HIV Managers and HREP, fostering more personalized discussions and refining outreach strategies to boost survey responses.
4. Participated in outreach events to expand reach and encourage survey completion
5. Partnered with a Social Work intern at the Tuscaloosa County Health Department to distribute surveys within STD and Family Planning clinic to increase engagement among population of focus.

Throughout the needs assessment process, multiple strategies were implemented to systematically address identified needs and limitations while ensuring methodological rigor and relevance to partners. Data collection activities were designed to surface structural, social, and service-level challenges, and findings were iteratively used to refine engagement approaches. Targeted outreach was conducted with populations of focus to understand gaps in access, while collaboration with ASOs facilitated the identification of locally specific challenges and feasible interventions. When participation challenges emerged, such as limited response rates, logistical constraints, or stakeholder fatigue, adjustments were made to recruitment methods, timelines, and communication strategies to enhance representation. Additionally, qualitative insights from interviews, surveys, and focus groups were synthesized to inform actionable recommendations, ensuring that the assessment not only documented unmet needs but also generated practical strategies to mitigate constraints and strengthen service delivery systems. Through this adaptive and participatory approach, the needs assessment process supported a more accurate understanding of shared experiences and guided the development of responsive, data- driven priorities.

Section IV: Situational Analysis

The HIV epidemic in Alabama remains a significant public health concern, shaped by intersecting social, structural, and epidemiological factors. This situational analysis synthesizes a comprehensive, participatory discussion of the epidemic by integrating statewide surveillance data with surveys of individuals vulnerable to HIV acquisition (n=585), PWH (n=325), provider assessments (n=115), HIV Knowledge and Practice surveys (n=288), and focus group findings. Together, these data provide a comprehensive, stakeholder-informed understanding of HIV burden and the performance of prevention and care systems across the state.

Epidemiologic findings demonstrate that HIV disproportionately impacts Black/African American individuals, who comprised 56.3% of individuals vulnerable to HIV acquisition and 64.7% of PWH surveyed, as well as MMSC, cisgender women, youth, and young adults (ages 13–34), Latino populations, and PWID. Economic vulnerability is a defining feature of the epidemic, with 51% of individuals vulnerable to HIV acquisition and 77.5% of PWH reporting annual incomes below $40,000. Age distribution reflects ongoing transmission among younger populations (53.8% of respondents vulnerable to HIV acquisition aged 16-44), alongside an aging population of PWH (76.1% aged 45 and older), indicating increasing demand for long-term HIV care and comorbidity management. Geographic gaps further compound these differences, as nearly 20% of PWH reported living in rural areas where access to HIV specialty care, transportation, and healthcare infrastructure is limited.

Across the care continuum, social and structural determinants of health, including poverty, housing instability, travel inconvenience, food insecurity, and stigma, emerge as fundamental drivers of health outcomes. Among PWH, the most frequently reported unmet service needs were food services (12.9%), non-medical case management (9.2%), and emergency financial assistance (8.9%), underscoring the importance of wraparound support services to sustain engagement in care. Focus group findings further highlight stigma, fear of disclosure, confidentiality concerns, and medical mistrust as persistent hindrances that limit testing, prevention uptake, and retention in care.

Building on the findings of this situational analysis, the following sections outline key strengths, challenges, and priority needs across each of the four EHE pillars. These insights will guide targeted, data-driven strategies to reduce new HIV infections, improve health outcomes for people with HIV, and advance fairness in health outcomes across Alabama.

Figure 7: SWOT Analysis



Diagnose: Testing and Early Identification

VOICES FROM PEOPLE WITH LIVED EXPERIENCE

"Because my main concern was that when I arrived, the first thing the nurse noticed was my last name. She said, "Are you related to..." and mentioned several names. I replied, "Yes." Then she added, "That's my best friend." I thought, oh no. If this gets out, I can already imagine it being on Channel 8 news. It's going to spread everywhere. I understand there are confidentiality rules with HIPAA and everything. However, at that moment, I wasn't thinking about that. This nurse was casually mentioning family members, and when she said my mom's name, I thought, oh no, no..." -Person vulnerable to HIV acquisition Focus Group Participant

"I was also considering that while we discuss sex extensively, which is a major source of HIV spread, there are additional methods of transmission, such as the use of needles and similar practices, especially for those who might inject drugs. It seems to relate to the issue of how we make judgments. Certain groups face scrutiny for their behaviors. When we refer to individuals who are involved in these activities, it's essential to examine our preconceived notion and strive to remain non-judgmental in these contexts. - Person vulnerable to HIV acquisition Focus Group Participant

"I was unaware that my gynecologist wasn't conducting an HIV test. I had no idea. When they mentioned they would perform a blood test to check my health, I didn't realize that an HIV test wasn't part of it. It's concerning not to be informed about what tests are being done." - Person vulnerable to HIV acquisition Focus Group Participant

"That's one reason many young people and others hesitate to undergo testing, due to a lack of information. They don't realize that it's possible to have a long life with it. " -PWH Focus Group Participant

Alabama has built a strong foundation for HIV testing, with services available in all 67 counties through county health departments, ASOs, and disease intervention specialists. Yet, the data tells a more complicated story. According to the needs assessment findings, nearly one in five individuals vulnerable to HIV acquisition have never been tested, and many others report only a single lifetime test. These gaps are not simply about availability; they reflect how people experience the system.

For many, the decision to test is shaped long before they enter a clinic.

In smaller or close-knit societies, concerns about confidentiality can outweigh the benefits of knowing one's status. One participant described how a routine visit quickly became uncomfortable when a provider casually referenced a family connection. In that moment, trust was disrupted. Despite protections under the Health Insurance Portability and Accountability Act (HIPAA), the perception of being recognized and potentially exposed was enough to create hesitation. These experiences highlight that confidentiality must not only exist in policy but be consistently demonstrated in practice.

Others described communication gaps that led to missed diagnostic opportunities. Some individuals assumed HIV testing was included in routine bloodwork, only to realize later it was not. Without clear, transparent conversations about what is being tested and why, patients are left without the information needed to make informed decisions about their health. This underscores the importance of strengthening routine opt-out testing practices and ensuring patients are actively engaged in their care.

The voices of people with lived experience also emphasized the need for more comprehensive and nonjudgmental education. While sexual transmission is frequently discussed, participants noted that other risk factors, such as injection drug use, are often overlooked or stigmatized. This narrow framing can alienate individuals and reinforce harmful assumptions, making it less likely that people will seek testing or disclose risk behaviors. Effective prevention requires messaging that is all-encompassing, accurate, and free of judgment.

For younger individuals in particular, limited awareness about HIV treatment and outcomes continues to influence testing behavior. Many are unaware that HIV is a manageable condition with proper care, leading to fear and avoidance rather than proactive engagement. Expanding education that emphasizes the importance of long, healthy lives through treatment is critical to shifting perceptions and encouraging routine testing.

Together, these experiences reveal that challenges to early diagnosis are not solely structural; they are deeply human. They are rooted in trust, communication, perception, and understanding. Alabama's testing infrastructure provides a critical opportunity, but its impact depends on how well it aligns with the needs and realities of the people it serves.

Advancing early HIV diagnosis in Alabama will require more than expanding services. It will require strengthening patient-provider communication, reinforcing confidentiality in practice, delivering comprehensive and stigma-free education, and normalizing routine testing across all healthcare settings. By centering the lived experiences of individuals, the state can move from service availability to meaningful and sustained engagement in care.

Treat: Continuity of Care and Viral Suppression

VOICES FROM PEOPLE WITH LIVED EXPERIENCE

"I received my diagnosis in the emergency department. I underwent tests, and the physician recommended a follow-up. He delayed it for a couple of weeks but did ask if I would agree to a HIV test, which I accepted. They informed me only when I returned, and the doctor stated, "You're HIV-positive." I felt that he lacked the necessary training to manage a patient's reaction to a new diagnosis effectively. I mentioned this to him, and he responded, "Didn't you know you had HIV?" Even after all this time, it still lingers in my mind, and the way he delivered the news continues to trouble me." -PWH Focus Group Participant

"…a lot of people will turn against you when they find out you have HIV." -PWH Focus Group Participant

"The pharmacy is yet another variable in our service that lacks consistency. I try to use Curant as often as possible, but in line with his statement, when I don't have my medications, I depend on them for my health, particularly the HIV medications. Without them, it becomes a significant issue, a complete failure, really. Due to the way they are shipped, they claim to send them overnight. For example, take this past week. Veterans Day fell on Tuesday. If they sent them out on Friday, they probably won't arrive until Thursday. It may sound absurd, but it really isn't. I don't receive them on Monday because if they were dispatched on Friday afternoon, they won't even enter the system until Monday. They aren't processed on Tuesday either. Monday. Then we have Wednesday and typically Thursday, meaning I could be without them for a week, which indicates a flaw in that specific provider's process." -PWH Focus Group Participant

"I believe that some of the challenges we face stem from coming from a smaller town. Our town isn't as large as Birmingham. There are instances where friends of ours, who have received a diagnosis, are unable to access healthcare because they lack transportation to Birmingham, and they fear that others will learn about their situation if they ask for a ride to the doctor. Many of them end up forgoing treatment. They might start on their first or second round of treatment but then struggle with issues like, "I can't communicate with you on the phone since my family is unaware," or, "I can't find anyone to take me to the doctor, which is a 45-minute drive every month," to understand the reason for the visit. These represent significant obstacles in smaller towns. In larger places like Birmingham, different lifestyles are more widely accepted. However, in smaller towns where there are only a couple of schools and everyone knows each other, it's a different story." - Person vulnerable to HIV acquisition Focus Group Participant

Alabama's HIV care system is supported by the Ryan White HIV/AIDS Program, including the AIDS Drug Assistance Program (ADAP) and the HIV Re-Engagement Program, designed to ensure access to treatment and support services regardless of insurance status. The recent expansion of ADAP eligibility to 500% of the federal poverty level represents a critical step toward closing coverage gaps in a non-Medicaid expansion state.

Increasing the FPL eligibility for ADAP expanded access to HIV antiretroviral therapy (ART) for individuals who fall into the coverage gap due to non-Medicaid expansion (make too much for Medicaid but lack resources to consistently afford HIV medication and related care).

Yet, despite these advancements, continuity of care remains a challenge. Approximately 15% of people with HIV report a lapse in care of at least 12 months, underscoring that access alone is not sufficient to sustain engagement.

The voices of people with lived experience illustrate how these gaps emerge, not as isolated failures, but as a series of experiences that shape trust, stability, and the ability to remain in care over time.

For some, the challenge begins with diagnosis. Individuals described receiving life-changing news in ways that felt abrupt and unsupported, with limited explanation or emotional consideration. These experiences can leave lasting impressions, influencing how individuals perceive the healthcare system and whether they feel comfortable returning for follow-up care. A diagnosis delivered without empathy or context can become an early hindrance to long-term engagement.

For others, continuity of care is disrupted by stigma and fear of disclosure. In smaller or close-knit towns, the risk of being identified when seeking services remains a significant concern. Individuals may delay or disengage from care to protect their privacy, particularly when transportation to larger cities is required or when support systems are limited. The fear of social consequences, of being judged, isolated, or treated differently, continues to shape decisions about whether to remain in care.

Structural challenges further complicate retention. Participants described challenges navigating care systems, including limited knowledge of available services, gaps in case management, and difficulties coordinating appointments and referrals. Behavioral health needs also play a significant role, with many individuals facing psychological challenges that impact their ability to engage in care consistently.

Reliability of medication access is another critical factor. Delays in pharmacy processing and medication delivery were described as disruptive and, at times, dangerous. For individuals who depend on daily antiretroviral therapy, even short interruptions can create anxiety and undermine treatment adherence. These inconsistencies highlight the importance of strengthening pharmacy systems and ensuring timely, dependable access to medications.

Geographic challenges remain particularly pronounced in rural areas, where transportation challenges and long travel distances make regular care difficult to maintain. Confidentiality concerns often compound these logistical challenges, as seeking assistance may inadvertently disclose an individual's HIV status within their group.

Together, these experiences demonstrate that a complex interplay of structural, social, and interpersonal factors influences continuity of care. While Alabama has established a comprehensive system of HIV care, gaps in communication, coordination, access, and trust continue to affect long-term engagement and viral suppression outcomes.

Strengthening continuity of care in Alabama will require a sustained focus on patient-centered approaches that extend beyond service availability. This includes improving the quality and sensitivity of diagnosis experiences, enhancing care coordination and navigation, ensuring reliable access to medications, addressing transportation and geographic challenges, and reducing stigma across regions and healthcare settings. By aligning systems of care with the lived experiences of individuals, Alabama can improve retention, support viral suppression, and advance progress toward ending the HIV epidemic.

Prevent: Prevention and Awareness

"Why wait 'til the university [age] —why wait until somebody's active? That is information [and] education that you start sooner." - Person vulnerable to HIV acquisition Focus Group Participant

"I don't think that the problem is the information about PrEP, but how we get the information delivered." -Person vulnerable to HIV acquisition Focus Group Participant

VOICES FROM PEOPLE WITH LIVED EXPERIENCE CONT.

"I do feel like there should probably be a better education aspect in major hospitals, Huntsville Hospital, UAB, major hospitals in Alabama, because I feel like they also don't necessarily address sexual health and wellness as well. I feel like they could do a better, the major hospitals could do a better job at that in referring." - Person vulnerable to HIV acquisition Focus Group Participant

"I see a primary care outside of the board of health. A lotta them do not know a whole lot about HIV. They know some, but they don't know a whole lot."-PWH Focus Group Participant

"I reside in Lowndes County, and there are truly no locations available in this county where residents can access those resources or even obtain free services. They must travel to either Montgomery or Selma. It would e helpful to have a list of locations where individuals can find information about free healthcare options, including transportation." -Person vulnerable to HIV acquisition Focus Group Participant

Alabama's HIV prevention efforts reflect a strong and evolving system, one that includes testing, condom distribution, partner services, and innovative strategies such as mobile units and harm reduction approaches. However, despite these efforts, gaps in awareness and utilization of biomedical prevention persist. A significant proportion of individuals remain unaware of key tools such as PrEP, PEP, and Undetectable = Untransmittable (U=U), even as interest in these interventions remains high.

The voices of people with lived experience highlight that the challenge is not solely the availability of prevention services, but how those services are experienced, understood, and accessed.

For individuals living in rural areas such as Lowndes County, prevention is often limited by geography. Participants described having no local access points for HIV prevention services, requiring travel to neighboring cities such as Montgomery or Selma. Without reliable transportation or clear information about available resources, even highly motivated individuals may be unable to engage in prevention services. These experiences underscore the need for more localized access and improved visibility of existing resources, including transportation support.

At the same time, participants emphasized that awareness alone is not enough. While some individuals have heard of PrEP, they noted that current messaging does not always resonate or reach the intended audiences effectively. The way information is delivered, whether through trusted messengers, relevant platforms, or accessible language, plays a critical role in whether prevention tools are understood and utilized.

People with lived experience also identified gaps in the timing and scope of education. Many expressed that HIV prevention and sexual health education should begin earlier, before individuals become sexually active, rather than being introduced reactively. Earlier, more comprehensive education can equip individuals with the knowledge needed to make informed decisions and reduce risk over time.

Healthcare settings were also highlighted as missed opportunities for prevention. Participants noted that sexual health and HIV prevention are not consistently addressed in primary care or hospital settings, and that some providers may lack sufficient knowledge of current prevention strategies. Strengthening provider education and integrating routine prevention discussions into standard care can help normalize HIV prevention and increase uptake.

Collectively, these perspectives illustrate that a combination of geographic, informational, and organizational factors shapes challenges to prevention. While Alabama has established a broad prevention infrastructure, gaps in access, communication, and provider engagement continue to limit its full impact.

Advancing HIV prevention in Alabama will require a comprehensive, societal approach that goes beyond service availability. Efforts must prioritize expanding access in rural areas, improving the delivery of prevention information, integrating education earlier in the life course, and strengthening providers' capacity to engage in prevention conversations. By aligning prevention strategies with the lived experiences of individuals, Alabama can increase awareness, improve uptake of biomedical interventions, and reduce new HIV transmissions statewide.

Respond: Cluster Detection & System Coordination

VOICES FROM PEOPLE WITH LIVED EXPERIENCE

"...it's disheartening when obstacles arise and people say one thing while their actions show something different. It leaves you wondering who you can rely on for assistance. It's annoying, and like I mentioned earlier, there was a moment when I just threw my hands in the air and declared, "I've had enough. I'm exhausted from battling. I'm worn out. I'm weary of trying to make my case. Who can support me?" -PWH Focus Group Participant

"They lead you on a pointless errand. They ask you to arrive with all the necessary documents. They act like, "Oh, we need to check again. You must do this. You must handle that." You're aware of my situation. I'm already registered. It shouldn't require so much effort to receive assistance. Your diagnosis should be straightforward. Just proceed directly." -PWH Focus Group Participant

"Sometimes, agencies are created to offer assistance, support, and care, but they can't fulfill this role because they lack connections with the other agencies that referred you." -PWH Focus Group Participant

Alabama's HIV response system is built on strong partnerships, bringing together public health agencies, healthcare providers, and partner organizations to detect and respond to emerging HIV needs. These coordinated efforts are essential to identifying transmission patterns, linking individuals to care, and guiding data-driven decision-making. However, as service demand continues to grow and resources become more constrained, the system is under increasing strain.

The challenge is not a lack of commitment; it is how the system functions in real time.

For individuals navigating care, coordination is not experienced as a seamless network. It is experienced as a series of steps, often unclear, sometimes repetitive, and occasionally overwhelming.

One participant described the exhaustion of trying to access support, being asked to provide the same documents multiple times, being asked to revisit processes that should already be complete and having to advocate continuously for services they were already eligible for. What should have been straightforward became burdensome. Over time, frustration gave way to fatigue.

“I’m exhausted… Who can support me?”

This sense of fatigue reflects more than individual frustration; it points to organizational inefficiencies that place the burden of coordination on the person seeking care, rather than on the system designed to serve them.

Others described being referred from one agency to another, only to find that those agencies were not effectively connected. Services existed, but the pathways between them were unclear or incomplete. As a result, individuals experienced delays, gaps in care, or missed opportunities for support altogether.

In these moments, the system does not feel integrated; it feels fragmented.

These experiences are further compounded by challenges within the state’s data infrastructure. Limitations in real-time data access, interoperability between systems, and workforce capacity reduce the ability to quickly identify and respond to emerging HIV needs. A recent technical issue affecting the transfer of laboratory data between surveillance systems underscores the importance of reliable, timely data. Without accurate and complete information, it becomes more difficult to fully understand care engagement, measure outcomes such as viral suppression, and respond effectively at both the individual and population levels.

At the same time, increasing demand for services alongside declining funding places additional pressure on an already stretched workforce. Providers are tasked with meeting complex needs within constrained systems, contributing to inconsistencies in service delivery and missed opportunities for timely intervention.

The voices of people with lived experience make clear that these challenges are not abstract; they shape real decisions about whether to remain engaged in care. When processes are overly complex, communication is inconsistent, or follow-through is lacking, individuals may disengage not because services are unavailable but because the process is difficult to navigate.

An effective HIV response system must function as a coordinated whole, not a collection of separate parts.

Strengthening Alabama’s response will require integrated data systems, streamlined service navigation, stronger cross-agency coordination, and sustained investment in workforce capacity. Equally important is ensuring that systems are designed with the user experience in mind, reducing unnecessary complexity and building trust through clear communication and reliable follow-through.

When systems are connected, responsive, and easy to navigate, they do more than deliver services; they ensure no one is lost in the system.

Populations of Focus

Alabama's Integrated HIV Prevention and Care Plan prioritize populations disproportionately impacted by HIV, including:

i. Black and Latino Men who have male-to-male sexual contact (MMSC)
ii. Black Cisgender Women
iii. People with substance abuse disorder
iv. Youth and young adults (ages 13-34)

The populations experience higher rates of HIV acquisition and poorer outcomes across the HIV Care Continuum due to a combination of structural unfairness, stigma, limited access to responsive care, and social determinants of health.

In addition, the plan elevates a strategic focus on populations that have historically been neglected in HIV programming, such as rural towns, people experiencing homelessness, justice-involved, and Tribal/Native American populations. Recognizing geographic isolation, limited healthcare infrastructure, gaps in outreach, and challenges such as housing instability and limited continuity of care, the plan supports innovative approaches such as mobile testing units, telehealth, and strengthen partnerships with Indian Health Services (IHS) and rural providers to improve access and engagement.

The goals and objectives of Alabama's Integrated HIV Prevention and Care Plan are intentionally designed to address the needs of people and communities disproportionately impacted by HIV by prioritizing fairness, expanding access to services, reducing obstacles, and strengthening stakeholder-centered approaches.

The plan recognizes that HIV does not affect all populations equally. Rural communities, Black and Latino populations, Native Americans, people experiencing homelessness, individuals involved in the justice system, people who use substances, and uninsured or underinsured individuals often face greater obstacles to prevention, testing, treatment, and long-term care. The goals and objectives respond to these disparities through targeted strategies across all four pillars of the Ending the HIV Epidemic initiative.

Under Goal 1, the plan expands HIV testing and prevention services in under-resourced and high-burden neighborhoods through mobile testing units, outreach at engagement events, testing in correctional facilities, shelters, substance use treatment programs, and re-entry settings. These activities are designed to bring services directly to populations that may not routinely access traditional healthcare systems. The plan also promotes context awareness, education materials, and targeted media campaigns to improve awareness among populations of focus.

Goal 2 focuses on improving health outcomes for people with HIV by addressing hindrances that disproportionately affect vulnerable populations. Objectives include improving linkage to care, retention, viral suppression, and patient navigation services. Activities such as transportation

assistance, telehealth expansion, case management, re-engagement outreach, and support for housing, food insecurity, behavioral health, and substance use needs directly address social determinants of health that contribute to disparities in HIV outcomes.

Goal 3 specifically emphasizes fairness in health and the reduction of disparities across populations. The plan includes strategies to strengthen partnerships that address the social determinants of health, increase outreach in areas with limited access to services, and improve engagement with Black, Latino, and Native American populations. Examples include partnerships with tribal health representatives, outreach at Latino hubs, and expanded mobile outreach services. This goal also prioritizes reducing HIV-related stigma through provider training, trauma-informed care, public awareness campaigns, and people-led storytelling initiatives that elevate lived experiences and normalize HIV prevention and treatment.

In addition, the plan expands access to evidence-based prevention strategies, including PrEP, PEP, and U=U messaging, through targeted campaigns and provider education. These approaches are especially important for populations vulnerable to HIV acquisition who may face limited awareness or access to prevention services.

Goal 4 strengthens coordination, surveillance, stakeholder engagement, and data-driven decision-making to ensure resources are directed where disparities are greatest. The plan incorporates listening sessions, involvement of people with lived experience, cross-sector collaboration, and routine evaluation of disparities and service gaps. This ensures that interventions remain responsive to public needs and that resources are prioritized in areas with the highest HIV burden.

Overall, the goals and objectives address disproportionate HIV impact by:

- Expanding services into areas with limited access to services and non-traditional settings,
- Reducing structural and social impediments to care,
- Promoting compassionate care and trust in services,
- Prioritizing populations and geographic areas with the greatest disparities,
- Incorporating stakeholder voices and lived experience into planning and implementation; and
- Using data to guide allocation of resources and interventions.

These combined strategies support a fairer HIV prevention and care system across Alabama and align with national Ending the HIV Epidemic priorities.

Section V: 2027-2031 Integrated HIV Workplan

The 2027-2031 HIV Prevention and Care Integrated Plan reflects a unified, data-driven commitment to ending the HIV epidemic. It provides a clear roadmap for the next five years, translating broad priorities into coordinated, actionable steps that strengthen prevention, care, and response efforts.

At the core of this plan is a structured framework that connects vision to implementation. Each component- goals, objectives, strategies, and activities- builds on the next to ensure that daily efforts align with long-term impact.



Goals: The Vision

The goals represent the overarching vision for this period. They focus on reducing new HIV infections, improving access to fair, high-quality care, and eliminating persistent variances among disproportionately affected populations. These goals define the direction of the plan and the outcomes it seeks to achieve.



Objectives: The Benchmark

The objectives translate these goals into measurable benchmarks. By setting specific targets, such as increasing viral suppression, improving linkage to care, and expanding PrEP access, the plan establishes clear indicators of progress and accountability over time.



Activities: The Implementation

The activities represent the implementation of these strategies through concrete, on-the-ground actions. From expanding mobile testing and streamlining care linkage to conducting outreach and education, these efforts drive day-to-day progress and ensure services reach the people most in need.



Moving Toward 2031

This framework creates a cohesive, adaptable roadmap that remains responsive to shifting public health needs. By aligning high-level vision with ground-level action and centering fairness at every stage, the HIV Integrated Plan serves as a practical engine for measurable progress. It is designed specifically to strengthen systems of care and improve health outcomes across the entire jurisdiction.

As implementation progresses through Year 1 and beyond, some objectives and activities may not initially include fully developed measurable benchmarks, such as measure definitions, baseline values, and Year 5 targets. Additional data collection, stakeholder engagement, program refinement, and assessment of available surveillance and monitoring systems will help inform the development and finalization of these measures over time. In some cases, new activities may require establishing data collection processes before reliable baselines and targets can be determined. This phased approach allows the plan to remain flexible, data-informed, and responsive to emerging priorities, evolving public health needs, and improvements in program capacity and data quality.

This narrative is more than a formal document; it is a living strategy built to evolve alongside the public health landscape. By ensuring daily activities directly support long-term goals, the Integrated Plan remains a robust and transparent tool for advancing fairness in health outcomes and promoting sustainable change.

Integrated HIV Prevention and Care Plan Work Plan and Monitoring Table, 2027-2031						
Goal 1: Prevent New HIV Infections						
Objective 1.1: By the end of 2031, reduce the number of new HIV diagnoses by 10% by expanding routine, targeted, and community-based testing						
EHE Strategy: Diagnose (Prevent)						
Activity/Performance Measure	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Year 5 Target**	**Data Source**	**Responsible Parties (Including Data Staff & Program Staff)**
Objective 1.1	**Annual number of new HIV diagnoses**	**2023**	**710**	**639**	**eHARS**	**Prevention Epidemiologist**
1.1.1 Conduct HIV testing through mobile units in rural areas with limited access to services.	Number of HIV tests conducted via mobile units	2024	887		Subrecipient activity reports	ASOs
1.1.2 Provide rapid HIV testing at engagement events, including health fairs, college campuses, and festivals.	Number of HIV testing events conducted	2024	1796		HADIS, ALNBS	HIV District Managers, DIS, ASOs
1.1.3 Expand HIV/STI and HCV testing into substance use treatment programs, bars, nightclubs, unsheltered outreach programs, shelters, and organizations serving people experiencing homelessness.		2024	295			
1.1.4 Establish HIV testing programs within correctional facilities, county jails, and re-entry programs.		2024	647[3]			

[3] Baseline values presented for activities 1.1.1-1.1.4 represent estimated counts of HIV tests conducted in event-based settings. These values should be interpreted with caution, as they may be subject to variation in data collection methods.

1.1.5 Increase awareness of STI/HIV self-testing through outreach events and campaigns.	Number of self-test kits distributed and returned	2024	6,810 ordered; 4,209 returned	10,000 ordered; 8,500 returned	imaware	
1.1.6 Implement public awareness campaigns promoting HIV testing and early diagnosis through social media and media campaigns.	Number of media campaigns implemented; reach and engagement metrics (impressions, clicks, shares); percentage increase in testing uptake following campaigns (if available).				Media analytics	ASOs
Objective 1.2: By the end of 2031, reduce the percentage of late HIV diagnoses (Stage 3 at diagnosis or within 6 months of diagnosis) by 10%.						
EHE Strategy: Diagnose						
Activity/Performance Measure	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Year 5 Target**	**Data Source**	**Responsible Parties (Including Data Staff & Program Staff) & Notes**
Objective 1.2	**Number and percentage of individuals diagnosed with Stage 3 at diagnosis or within 6 months of diagnosis**	**2023**	**161 (20%)**	**145 (10%)**	**eHARS**	**Prevention Epidemiologist**
1.2.1 Provide training to healthcare providers on CDC HIV testing recommendations and routine opt-out testing practices.	Number and percentage of healthcare providers trained on CDC HIV testing recommendations and opt-out testing practices; percentage demonstrating increased knowledge post-training.				Training attendance logs; pre/post training assessments	AETC, Grant TA Provider
1.2.2 Establish a partnership with 1 major hospital system in the East Central District to provide opt-out HIV testing.	**Measure not defined**				Memoranda of Understanding (MOU)	OHPC
1.2.3 Incorporate HIV testing and PrEP reminders into EHR/EMR.	Number of healthcare systems implementing EHR/EMR prompts for HIV testing and PrEP; percentage of eligible patients receiving prompts.				EHR/EMR system reports	ASOs

1.2.4 Promote annual HIV testing recommendations through media campaigns and social media targeting populations of focus.	Number of media campaigns implemented; reach and engagement metrics (impressions, clicks, shares); percentage increase in testing uptake following campaigns (if available).				Media analytics	
1.2.5 Collaborate with surveillance to monitor testing every 6 months and late diagnosis indicators.	Trend in HIV testing volume and percentage of late diagnoses over time.				eHARS, HADIS, ALNBS	Prevention Epi, Integration Coordinator, STD Surveillance
Objective 1.3: By the end of 2031, increase access to and utilization of integrated HIV, STI, HCV, and TB screening services among populations of focus through expansion of community-based, non-traditional, and co-located testing initiatives and cross-program partnerships.						
EHE Strategy: Diagnose (Prevent, Respond)						
Activity/Performance Measure	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Year 5 Target**	**Data Source**	**Responsible Parties (Including Data Staff & Program Staff)**
Objective 1.3	**Number and percentage of individuals receiving HIV, STI, HCV, and/or TB testing**				**HADIS, TB surveillance**	**Prevention Epidemiologist, STD Surveillance, TB Epidemiologist**
1.3.1 Establish a formal partnership with the Division of Tuberculosis (TB) Control to coordinate HIV &TB screenings and share data to identify co-infection trends.	**Measure not defined**				MOU/Data sharing agreement	OHPC
1.3.2 Collaborate with correctional facilities and re-entry programs to provide integrated HIV/STI/HCV/TB testing and linkage to care.	Number of correctional and re-entry sites implementing integrated screening; number and percentage of individuals tested and linked to care.				Subrecipients' activity report	ADPH & ASOs
1.3.3 Partner with organizations serving people experiencing homelessness to implement routine, on-site integrated screening services.	Number of partner organizations providing on-site screening; number and percentage of individuals screened and linked to services.					ASOs

1.3.4 Expand mobile health unit capacity to deliver integrated testing services in rural and high-burden areas.	Number of mobile unit events conducted; number of individuals tested through mobile services; geographic coverage in priority areas.					
1.3.5 Develop and distribute context-aware education materials addressing HIV/STI/HCV prevention, TB transmission, symptoms, and treatment. and co-infection risks.	Number of educational materials developed and distributed; number of individuals reached; participant knowledge increase (if assessed).				Subrecipients' activity reports and evaluation surveys (if applicable)	OHPC, ASOs, Division of TB & STD
1.3.6 Utilize and share surveillance and program data to identify geographic areas and populations with overlapping HIV and TB prevalence and prioritize outreach accordingly.	Number of regions identified as co-burden areas				eHARS, HADIS, ALNBS, TB surveillance data	OHPC Prevention Director, Integration Coordinator, Division of TB Director
Goal 2: Improve Health-Related Outcomes for People with HIV						
Objective 2.1: By the end of 2031, the percentage of individuals newly diagnosed with HIV who are linked to medical care within 30 days of diagnosis to 82%						
EHE Strategy: Treat						
Activity/Performance Measure	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Year 5 Target**	**Data Source**	**Responsible Parties (Including Data Staff & Program Staff)**
Objective 2.1	**Percentage of individuals newly diagnosed with HIV who are linked to medical care within 30 days of diagnosis**	**2023**	**79%**	**82%**	**eHARS**	**Prevention Epi**
2.1.1 Conduct follow-up outreach for individuals who miss initial care appointments.	Number and percentage of newly diagnosed individuals who missed initial appointments and received follow-up outreach; percentage who have a successful outreach				eHARS, EHR/EMR reports	ASOs, HIV Managers, DIS

2.1.2 Establish a rapid referral system between testing sites and HIV care providers.	Number of referral systems established; percentage of newly diagnosed individuals referred to and linked to care within 7 days				eHARS	
Objective 2.2: By the end of 2031, increase retention in HIV medical care to 60%						
EHE Strategy: Treat						
Activity/Performance Measure	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Year 5 Target**	**Data Source**	**Responsible Parties (Including Data Staff & Program Staff**
Objective 2.2	**Percentage of people with diagnosed HIV who have 2 or more labs at least 90 days apart within 12 months**	**2023**	**55%**	**60%**	**eHARS**	**Prevention Epi**
2.2.1 Implement appointment reminder systems, including phone calls, text messaging, and patient portal notifications.	Number and percentage of clients receiving appointment reminders; missed appointment rates before and after implementation				EHR/EMR system reports	ASOs
2.2.2 Provide transportation or transportation vouchers/gift cards to support medical appointment attendance.	Number of clients receiving transportation vouchers/gift cards				Gift card log	
2.2.3 Implement case management interventions for individuals experiencing access obstacles.	Retention rates among clients receiving case management				Ryan White Service Reporting (RSR), eHARS, case management report	
2.2.4 Utilize HREP to conduct re-engagement outreach for individuals identified as out of care through surveillance data, data-to-care, and the not-in-care (NIC) list.	Number of clients identified as out of care; number and percentage of clients re-engaged in care through HREP				REDCap, NIC list, eHARS	HREP & ASOs

2.2.5 Partner with organizations that provide supportive services addressing housing, food insecurity, and behavioral health needs.	Number of partnerships established; number of clients referred to supportive services; retention outcomes among referred clients				MOUs, case management report	OHPC, HREP, ASOs
2.2.6 Expand telehealth services for routine HIV care visits where clinically appropriate.	Number and percentage of clients utilizing telehealth services; retention and viral suppression rates among telehealth users				Clinic report	ASOs
Objective 2.3: By the end of 2031, increase viral suppression among people with HIV to 70%.						
EHE Strategy: Treat						
Activity/Performance Measure	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Year 5 Target**	**Data Source**	**Responsible Parties (Including Data Staff & Program Staff)**
Objective 2.3	**Percentage of people with diagnosed HIV who have a suppressed viral load at the most recent test**	**2023**	**66%**	**70%**	**eHARS**	**Prevention Epi**
2.3.1 Promote participation in the ADAP through outreach.	Number of individuals reached; number of individuals enrolled in ADAP annually				AIDS Drug Assistance Program Data Report (ADR)	OHPC Prevention and EHE staff, & ASOs
2.3.2 Collaborate with subrecipients to conduct periodic reviews to identify target hindrances to recertification.	Number and type of impediments identified; percentage resolved before the recertification deadline					OHPC ADAP staff & ASOs
2.3.3 Update eligibility policy to outline required documentation and examples of acceptable documentation.	Completion and dissemination of the updated ADAP eligibility policy					
2.3.4 Ensure subrecipients proactively address potential documentation hindrances before the recertification deadline.	Number and percentage of patients recertified on time.					

Objective 2.4: By the end of 2031, improve Ryan White client satisfaction to at least 70%, with a corresponding 5% increase in viral suppression in the southern region						
EHE Strategy: Treat						
Activity/Performance Measure	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Year 5 Target**	**Data Source**	**Responsible Parties (Including Data Staff & Program Staff)**
Objective 2.4	**Percentage of Ryan White clients reporting satisfaction with services, and corresponding percentage change in viral suppression among clients in the southern region**	**2025**	**60%**	**70% client satisfaction, corresponding 65% viral suppression**	**Client satisfaction surveys**	**OHPC Clinical Quality Management (CQM) staff**
2.4.1 Utilize client feedback to guide program improvements and quality improvement initiatives.	Number of program improvements implemented based on patient feedback; documentation of changes made					OHPC CQM staff & ASOs
2.4.2 Conduct client satisfaction surveys and focus groups to identify service gaps and opportunities for improvement.	Number of surveys and focus groups conducted; identified key themes					
2.4.3 Provide technical assistance to Ryan White providers to strengthen quality management programs.	Number of providers receiving technical assistance; improvements in quality management indicators post-assistance				TA logs	OHPC
2.4.4 Monitor service delivery indicators to ensure access to services across regions.	Number of corrective actions implemented				RSR, CQM report	OHPC CQM staff
Objective 2.5: By 2031, expand patient navigation services to improve linkage to care, retention, and re-engagement of individuals who are out of care through surveillance, data-to-care initiatives, and the NIC list.						
EHE Strategy: Treat						
Activity/Performance Measure	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Year 5 Target**	**Data Source**	**Responsible Parties (Including Data Staff & Program Staff) & Notes**

Objective 2.5	**Number and percentage of individuals identified as out of care (NIC list) who are successfully re-engaged in HIV medical care through HREP or patient navigation**	**2024**	**469/3,916[4]**		**REDCap**	**Hepatitis C Epi & HREP Manager**
2.5.1 Develop standardized patient navigation protocols across public health districts.	Completion and adoption of protocols					OHPC HREP
2.5.2 Recruit and train patient navigators to support linkage, retention, and re-engagement in care.	Number of patient navigators trained and demonstrating competency post-training					
2.5.3 Collaborate with ASOs to support outreach and re-engagement efforts.	Number of patients re-engaged through ASO collaboration.					
2.5.4 Implement feedback mechanisms from clients to improve navigation services and responsiveness to stakeholder needs.	Percentage of patients reported satisfaction with patient navigation services; number of feedback mechanisms implemented.					
Objective 2.6: Reduce perinatal transmission by increasing HIV screening, improving linkage to prenatal care and treatment, and ensuring viral suppression among pregnant people with HIV.						
EHE Pillar: Treat (Prevent, Respond)						
Activity/Performance Measure	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Year 5 Target**	**Data Source**	**Responsible Parties (Including Data Staff & Program Staff) & Notes**
Objective 2.6	**Number and percentage of infants diagnosed with HIV through perinatal transmission annually**				**eHARS**	**Prevention Epi**
2.6.1 Increase awareness and outreach related to perinatal HIV prevention	Number of outreach and education activities conducted on perinatal HIV prevention and maternal health				Activity reports	HIV Managers, OHPC EHE staff, ASOs

[4] HREP 2024 data included records imported from eHARS through a bulk upload process. Due to incomplete or missing data fields within several records, measure related to re-engagement in care should be interpreted with caution, as counts may underestimate or overestimate actual service engagement.

2.6.2 Strengthen provider education on perinatal prevention	Number of healthcare providers trained in perinatal HIV prevention, testing, and treatment guidelines				Training attendance logs, activity reports	AETC, Grant TA Provider & HIV Managers
2.6.3 Support viral suppression among pregnant individuals with HIV	Number and percentage of people with HIV who achieve and maintain viral suppression during pregnancy				eHARS	UAB Family Clinic, HREP
2.6.4 Improve linkage to perinatal and HIV care	Number and percentage of pregnant individuals newly diagnosed with HIV linked to HIV medical care within 30 days of diagnosis.				eHARS	UAB Family Clinic, HREP
2.6.5 Ensure routine review of perinatal HIV exposure cases and system gaps	Percentage of perinatal HIV exposure cases reviewed to identify missed prevention opportunities and system gaps.					UAB Family Clinic Medical Director, HREP Manager
Goal 3: Improve HIV Prevention, Care, and Treatment Outcomes for All Communities						
Objective 3.1: Strengthen statewide partnerships to address social determinants of health (SDOH) that impede access to HIV services and exacerbate HIV-related hindrances.						
EHE Strategy: Prevent (Treat, Respond)						
Activity/Performance Measure	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Year 5 Target**	**Data Source**	**Responsible Parties (Including Data Staff & Program Staff) & Notes**
Objective 3.1	**Number of partnerships and collaborative initiatives addressing SDOH**				**MOUs**	**OHPC & ASOs**
3.1.1 Establish formal partnerships/cross-sector coalitions with housing providers, food banks, and transportation services to address the social needs of individuals living with HIV.	Number of partnerships established				MOU	OHPC & ASOs
3.1.2 Promote HIV prevention and care services at outreach events.	Number of outreach events; number of individuals reached				Subrecipients' activity reports, Activity logs	

3.1.3 Partner with faith-based organizations and a trusted liaison to improve awareness of HIV services in areas with limited access to services.	Number of partnerships established with trusted liaisons and/or faith-based organizations; number of activities conducted in areas with limited access to services					
Objective 3.2: Ensure HIV education and testing reach communities and populations with the greatest need (Rural communities, Black, Latinos, Native Americans).						
EHE Strategy: Prevent (Respond)						
Activity/Performance Measure	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Year 5 Target**	**Data Source**	**Responsible Parties (Including Data Staff & Program Staff)**
Objective 3.2	**Number and percentage of HIV education and testing activities conducted in priority areas; number of individuals reached, tested, and linked to prevention or care services**				**HADIS, eHARS, ALNBS**	**HIV Managers, DIS, ASOs**
3.2.1 Develop prevention messaging campaigns promoting HIV testing, PrEP, and U=U awareness.	Number of campaigns developed and implemented; campaign reach and engagement metrics				Media analytics	ASOs
3.2.2 Establish a formal relationship with Poarch Creek Indians and Tribal health representatives.	**Measure not defined**					OHPC
3.2.3 Implement outreach testing at Latino hubs, such as markets, churches, and traditional events.	Number of outreach testing events; number of individuals tested and linked to care/prevention services				Subrecipients' activity reports	ASOs
3.2.4 Increase the number of mobile units and street outreach to bring services and resources to communities and populations where the need is greatest.	Number of interventions developed and implemented; populations reached					
Objective 3.3: Reduce HIV-related stigma that affects access to prevention, care, and treatment services						

EHE Strategy: Prevent (Treat, Respond)						
Activity/Performance Measure	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Year 5 Target**	**Data Source**	**Responsible Parties (Including Data Staff & Program Staff)**
Objective 3.3	**Measure definition to be determined**				**Data source to be determined**	
3.3.1 Provide training, technical assistance, and education for the HIV service delivery workforce on stigma, discrimination, implicit bias, and whole person care.	Number of trainings, TAs, or educational workshops conducted; percentage of attendees demonstrating increased knowledge or competency				Training logs; pre/post assessments	AETC, Grant TA Provider
3.3.2 Promote trauma-informed and whole-person approaches in HIV prevention and care settings.	Number of trainings, TAs, or educational workshops conducted; percentage of attendees demonstrating increased knowledge or competency				Training logs; pre/post assessments	OHPC, ASOs
3.3.3 Develop public awareness campaigns addressing HIV stigma.	Number of campaigns developed and implemented; changes in stigma indicators				Media analytics; evaluation reports	ASOs
3.3.4 Support storytelling and people-led initiatives that highlight resilience, treatment success, and lived experience.	Number of storytelling initiatives conducted; number of individuals engaged					OHPC & ASOs
Objective 3.4: Increase awareness of Hepatitis C (HCV) transmission, testing, and treatment by 20% through integrated HIV/HCV prevention education.						
EHE Strategy: Prevent						
Activity/Performance Measure	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Year 5 Target**	**Data Source**	**Responsible Parties (Including Data Staff & Program Staff)**
Objective 3.4	**Annual number of cases reported**	**2023**	**6,118**	**5200**	**ALNBS**	**Hepatitis C Epi**

3.4.1 Develop HCV education material for stakeholder engagement.	Number of materials developed					OHPC Hep C DIS & ASOs
3.4.2 Conduct educational workshops within substance use treatment programs and recovery centers.	Number of workshops conducted; number of participants				Subrecipients' activity reports; activity log	ASOs, Hep C DIS
3.4.3 Provide HIV and HCV testing and education at outreach events.	Number of outreach events providing integrated testing; number of individuals tested; number of individuals linked to care/prevention services.					OHPC Prevention, EHE, & Hep C staff & ASOs
Objective 3.5: Expand and improve implementation of safe, effective prevention interventions, including PrEP, PEP, and treatment as prevention (U=U)						
EHE Strategy: Prevent						
Activity/Performance Measure	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Year 5 Target**	**Data Source**	**Responsible Parties (Including Data Staff & Program Staff)**
Objective 3.5	**Number and percentage of individuals assessing PrEP**	**2024**	**4,779**	**4,880**	**AIDSVu**	**Integration Coordinator**
3.5.1 Conduct provider education on PrEP prescribing guidelines and clinical management via PrEP mail-out and newsletters.	Number of providers reached; number of trainings conducted; change in PrEP prescribing rate				AIDSVu; training log	Grant TA Provider, AETC
3.5.2 Implement targeted PrEP awareness campaigns focused on populations vulnerable to HIV acquisition.	Number of media campaigns implemented; reach and engagement metrics (impressions, clicks, shares); percentage increase in testing uptake following campaigns (if available).				Media analytics	OHPC & ASOs
3.5.3 Provide patient education materials explaining PrEP, PEP, and U=U.	Number of individuals receiving education				Subrecipient activity report; Activity log	OHPC Prevention and EHE staff, Division of STD & ASOs
Goal 4: Achieve Coordinated, Integrated Efforts That Address the HIV Epidemic Across All Sectors						
Objective 4.1: Detect and respond to emerging HIV clusters and time-space alerts using real-time surveillance and coordinated public health interventions						
EHE Strategy: Respond						

Activity/Performance Measure	Measure Definition	Baseline Year	Baseline Value	Year 5 Target	Data Source	Responsible Parties (Including Data Staff & Program Staff)
Objective 4.1	**Number and percentage of identified HIV clusters and time-space alerts reviewed and responded to within established response timelines.**				**Time space alerts, activity reports, cluster and molecular surveillance reports**	**Hepatitis C Epidemiologist, Integration Coordinator**
4.1.1 Conduct monthly surveillance reviews to assess alerts and prioritize investigations.	**Measure not defined**				Time Space Alerts	Epidemiologist
4.1.2 Complete post-response reviews after time-space alert or cluster investigation to inform continuous improvement of response activities.	Number and percentage of time space alerts/clusters investigations with completed response activities				Subrecipients' activity reports, time space alerts	OHPC
4.1.3 Develop data dashboards and reporting tools to support program monitoring and decision-making; to make program data accessible, user-friendly, and complete to influence positive change and quality assurance efforts.	**Measure not defined**					OHPC Data Management Staff
4.1.4 Collaborate with ASOs and CBOs to initiate public health response activities (testing, education, linkage to care, PrEP referral, partner services) within 30 days of identification.	Percentage of identified clusters or alerts with response activities initiated within 30 days, including testing, education, linkage to care, PrEP referral, or partner services				Subrecipients' activity reports	OHPC Program Coordinators/Directors

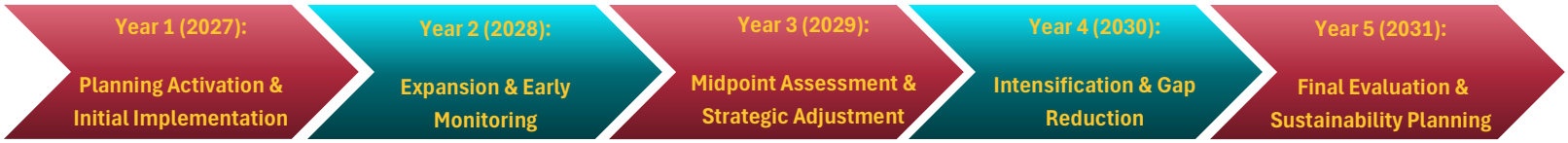
4.1.5 Strengthen collaboration between surveillance staff, program managers, and service providers to ensure timely use of data.	Number of cross-program coordination meetings conducted				Meeting minutes	OHPC
4.1.6 Create a formal cross-program collaboration framework that includes routine data sharing and coordinated response planning to support public health interventions.	**Measure not defined**					Integration Coordinator
Objective 4.2: Improve the completeness, timeliness, and accuracy of HIV surveillance and programmatic data systems to support real-time monitoring, identifying gaps and opportunities for improvements across the HIV care continuum, and inform data-driven planning and resource allocation						
EHE Strategy: Respond						
Activity/Performance Measure	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Year 5 Target**	**Data Source**	**Responsible Parties (Including Data Staff & Program Staff)**
Objective 4.2	**Measure to be determined**				**eHARS, program dashboards, HADIS**	**Data Management staff & ADPH IT**
4.2.1 Conduct routine data validation.	Percentage of identified data errors corrected				eHARS	Data Management Director & APDH IT Department
4.2.2 Provide technical assistance to providers and subrecipients on timely and complete data submission.	Number of providers and subrecipients receiving technical assistance; improvement in timeliness and completeness of submitted data				HADIS, Serology Forms	OHPC
4.2.3 Establish routine data review cycles quarterly to monitor key indicators across the HIV care continuum.	**Measure not defined**				eHARS	Integration Coordinator, Prevention Epi
Objective 4.3: Strengthen stakeholder engagement for people with lived experience to inform responsive HIV prevention and care strategies						
EHE Strategy: Respond (Treat, Prevent)						

Activity/Performance Measure	Measure Definition	Baseline Year	Baseline Value	Year 5 Target	Data Source	Responsible Parties (Including Data Staff & Program Staff)
Objective 4.3	**Measure to be determined**					
4.3.1 Recruit, train, and support people with lived experience to serve as members on the APCG, Ending the HIV Epidemic Advisory Committee (EHA), HIV Prevention Network (HPN), and consumer committees.	Number of people with lived experience recruited, trained, and actively participating in advisory groups and committees.				Committee rosters	OHPC & ASOs
4.3.2 Conduct listening sessions to gather input on HIV services and program priorities.	Number of listening sessions conducted; number of participants engaged; themes and recommendations documented.				Meeting summaries; attendance records, and evaluation reports	Integration Coordinator
Objective 4.4: Broaden the capacity of healthcare delivery systems, public health, and the healthcare workforce to improve context awareness and access to services						
EHE Strategy: Respond (Diagnose, Treat, Respond)						
Activity/Performance Measure	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Year 5 Target**	**Data Source**	**Responsible Parties (Including Data Staff & Program Staff)**
Objective 4.4	**Number and percentage of healthcare providers, public health professionals, community health workers, and service organizations receiving training or technical assistance to improve HIV prevention, care, and treatment services; number of systems or organizations implementing improved service delivery practices.**				**Training attendance logs, program monitoring reports**	**Integration Coordinator**
4.4.1 Promote best practices that support fairness in hiring, recruitment, and promotion	**Measure not defined**					OHPC, ASOs, & AETC

across the HIV service delivery workforce.						
4.4.2 Provide training and continuing education opportunities on HIV prevention, treatment, and comorbidities, and emerging HIV prevention and care strategies, and best practices.	Number of continuing education trainings conducted; number of participants				Number of trainings conducted; number of healthcare providers and social workers participating.	AETC, Grant TA Provider
Objective 4.5: Strengthen statewide monitoring, evaluation, and reporting systems to track progress towards HIV plan goals						
EHE Strategy: Respond						
Activity/Performance Measure	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Year 5 Target**	**Data Source**	**Responsible Parties (Including Data Staff & Program Staff)**
Objective 4.5	**Number of monitoring and evaluation reports produced quarterly, and percentage of objectives tracked.**				**Program reports**	**Integration Coordinator**
4.5.1 Use evaluation findings to guide program improvements and resource allocation.	**Measure not defined**					OHPC
4.5.2 Evaluate resources and ensure interventions are prioritized in communities with the highest incidence of HIV and related disparities.	**Measure not defined**					OHPC
4.5.3 Conduct biannual meetings to report progress towards goals of the Integrated Plan and revise objectives and activities as needed.	Number of objectives or activities revised based on findings.					OHPC Program Directors, STD Division Director, & Integration Coordinator
4.5.4 Conduct routine program performance reviews using surveillance and program data.	**Measure not defined**					OHPC

Section VI: 2027-2031 Integrated Planning Implementation, Monitoring, and Follow-up

Figure 8: 2027-2031 Integrated Timeline



The 2027–2031 implementation timeline reflects a structured, phased approach to achieving plan goals, beginning with foundational planning and initial implementation in Year 1, followed by expansion of activities and early performance monitoring in Year 2. Year 3 emphasizes a comprehensive midpoint assessment to evaluate progress and inform strategic adjustments, while Year 4 focuses on intensifying high-impact interventions and addressing persistent gaps and disparities. In Year 5, efforts conclude in a final evaluation and sustainability planning to ensure long-term impact.

This section outlines how Alabama will monitor progress toward achieving integrated plan goals and objectives through a structured, data-driven approach. It describes the processes for coordinating partners, aligning funding streams, and routinely monitoring performance using standardized indicators and integrated data systems. This section also explains how evaluation findings and stakeholder input, including PWH, will be used to inform continuous quality improvement and guide timely adjustments to strategies. Additionally, it details how progress will be communicated to stakeholders through regular reporting and dissemination to ensure transparency, accountability, and sustained engagement.

Implementation

Alabama will implement the 2027–2031 Integrated HIV Prevention and Care Plan through a coordinated, data-driven, and participatory approach that aligns with the EHE initiative and leverages both CDC and HRSA funding streams.

Implementation will be guided by formal governance structures, including the statewide integrated planning group (APCG), prevention and care workgroups, and district HIV Prevention Networks (HPN). These entities will ensure alignment across prevention, care, and treatment efforts, minimize duplication, and address service gaps.

A core component of the implementation approach is the meaningful and sustained engagement of PWH as partners in decision-making, program design, and service delivery. PWH will be actively integrated across all levels of implementation through:

- Representation on the integrated planning group, advisory committees, and workgroups with clearly defined roles in shaping priorities and strategies

- Engagement of PWH, including those from disproportionately impacted populations, to ensure an adaptive implementation
- Supportive services (e.g., transportation, virtual participation options) to reduce limitations and encourage consistent participation
- Utilization of peer-led models, including peer navigators and PWH-led organizations, to strengthen linkage, retention, and viral suppression efforts
- Routine feedback mechanisms (e.g., listening sessions, focus groups) to inform real-time program adjustments and improve service quality
- Integration of PWH perspectives into responsive messaging, outreach strategies, and service delivery design

As the jurisdiction transitions from planning to implementation, PWH engagement will move beyond advisory input to shared leadership and co-implementation, ensuring that programs reflect lived experience and are responsive to public needs.

The jurisdiction will actively coordinate partners across sectors, including:

- Public health and clinical providers
- AIDS Service Organizations and Community-based Organizations
- RWHAP subrecipients and HIV service providers
- Prevention subrecipients
- EHE subrecipients
- New and existing non-traditional partners (e.g., faith-based organizations, rural health providers)
- PWH and representatives of disproportionately impacted groups

Following plan submission, Alabama will further strengthen stakeholder engagement by leveraging and expanding existing meeting structures and advisory groups to support implementation, monitoring, and evaluation activities. This includes engaging the ADAP Advisory Workgroup to guide ADAP-specific objectives and using the Clinician Advisory Group to inform activities that require clinical expertise from physicians, nurses, physician assistants, nurse practitioners, and pharmacists. The state will also assess existing committees, workgroups, and partner meetings to identify opportunities for alignment, reduce duplication, and enhance coordinated decision-making.

Concrete steps will be taken to deepen engagement with external partners with defined roles in implementation. For example, collaboration with the AETC will be formalized to support workforce development, provider training, and clinical capacity building. Additional strategies will include establishing clear partner roles and expectations, integrating partners into performance review processes, creating feedback loops for continuous input, and embedding stakeholders into quality improvement activities. These efforts will ensure that implementation remains collaborative, accountable, and responsive to emerging needs.

Monitoring

Progress toward goals and objectives will be monitored using a structured, continuous quality improvement framework. Alabama will:

- Utilize data dashboards to track key indicators such as HIV diagnosis rates, linkage to care, viral suppression, PrEP uptake, and variances among populations of focus.
- Convene biannual planning group meetings and internal performance reviews to review progress, identify gaps, and recommend course corrections.
- Ensure cross-collaboration among partners to align timelines, activities, and outcomes.

Evaluation

Alabama will implement a comprehensive evaluation strategy to assess both process and outcome measures. Evaluation activities will include:

- Ongoing analysis of performance indicators biannually
- Annual formal evaluation reports assessing progress toward plan goals and objectives
- Use of both quantitative (surveillance and program data) and qualitative data (focus groups, stakeholder interviews)

Findings will be routinely presented to the integrated planning group, stakeholders, and leadership to inform decision-making and resource allocation.

Improvement

Continuous quality improvement will be embedded throughout the 5-year plan and beyond. Alabama will:

- Use data to identify service gaps and underperforming strategies
- Incorporate stakeholder input to guide revisions
- Conduct annual plan reviews and make formal updates as needed
- Allow for more frequent adjustments in response to emerging data, public health trends, or funding changes

Decision-making will be transparent and guided by data, stakeholder input, and fair considerations.

Reporting and Dissemination

Alabama will ensure ongoing communication of progress and outcomes through a structured dissemination strategy:

- Quarterly data briefs and dashboards shared with partners and stakeholders
- Biannual updates presented during APCG and APiC
- Annual progress reports made publicly available

Multiple dissemination channels will be used, including webinars, newsletters, and digital platforms. Materials will be context-aware and available in multiple languages as appropriate.