Integrated HIV Prevention and Care Plan

Alabama Department of Public Health
December 2022

Scott Harris, M.D., M.P.H.
STATE HEALTH OFFICER

November 14, 2022

CDC Grants Management Officer
Grants Management Branch, Procurements and Grants Office
Integrated HIV Prevention and Care Plan Guidance CY 2022-2026
Centers for Disease Control and Prevention (CDC)
2920 Brandywine Road
Atlanta, Georgia 30341-4146

Dear Officer:

On behalf of the statewide Alabama HIV Prevention and Care Group (HPCG) confirmed by consensus at its meeting on November 10, 2022 to concur with the following submission by the Alabama Department of Public Health in response to Integrated HIV Prevention and Care Plan Guidance, this letter fulfills the requirements of the **Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022 – 2026.**

The Alabama HIV Prevention and Care Group is comprised of 23 voting members, each Public Health District (8 districts) will have 2 voting members, 1 seats will be filled by Direct Care representatives, 1 seats will be filled by HIV Surveillance representative, 1 seat will be filled by an STD representative and 4 seats will be filled with People with HIV. The entire member body thoroughly reviewed the HPCG bi-laws with concurrence and no reservations.

This letter of concurrence meets the requirements of the Integrated HIV Prevention and Care Plan, is submitted on behalf of the HPCG and signed by the health department co-chair and community co-chair. Theses chairs have been designated as signatories to the letter of concurrence.

Agreed and accepted,

ADPH Co-Chair

ADPH Community Co-Chair

MAILING ADDRESS Post Office Box 303017 | Montgomery, AL 36130-3017
PHYSICAL ADDRESS The RSA Tower | 201 Monroe Street | Montgomery, AL 36104

alabamapublichealth.gov

PHAB
Advancing public health performance
Accredited Health Department

1. Executive Summary

The Ending the HIV Epidemic Alabama Plan 2020-2030 was developed in response to a Centers for Disease Control and Prevention (CDC) initiative aimed at reducing new HIV infections by 75 percent by 2025 and 90 percent by 2030. Alabama has been identified as one of the priority jurisdictions targeted for Phase I of the Ending the HIV Epidemic: A Plan for America (EHE) initiative. The Plan is the product of a collaborative process conducted through community meetings, focus groups, surveys, and provider interviews. Human immunodeficiency virus (HIV) prevention and care providers, people with HIV (PWH), and other community members participated in all data collection phases. The Plan reflects the vision of a community that has struggled with the effects of stigma, lack of health education, and limited resources in the most vulnerable populations of this state. Social determinants of health were given special consideration in the design of the Plan so that its interventions might reach Alabama's priority populations through community collaboration, and new and innovative prevention and care activities. Following an overview of the HIV crisis in Alabama, the collaborating participants created an EHE Alabama Plan composed of four main sections. 1. A community needs assessment conducted March-July 2020 identified gaps in HIV prevention and care planning relative to stigma, HIV education, lack of resources and cultural sensitivity. 2. A process of community engagement. 3. A timeline for implementation of specific activities across four tiers--diagnose, prevent, treat, and respond. 4. A plan to measure progress toward objectives. Recommendations made by the participants are included in the Situational Analysis. The use of effective interventions and peer-reviewed strategies ensures that populations identified as having the greatest risk for HIV transmission and acquisition receive the necessary resources to reduce new infections. This Plan is intended to be a living document to guide future prevention and care efforts in the state

2. Community Engagement and description of Jurisdictional Planning Process

The OHPC partners with AIDS Service Organizations (ASOs), community-based organizations (CBOs), non-profit organizations, government agencies, non-government public and private organizations, faith based organizations, colleges and universities, and others across the state to implement strategies that are based on the best available evidence across the four pillars of the EHE initiative: diagnose, treat, prevent, and respond. Alabama's EHE Jurisdictional Plan outlines implementation of comprehensive HIV prevention and treatment strategies that complement Ryan White and other U.S. Department of Health and Human Services programs designed to support ending the HIV epidemic in America by leveraging powerful data, tools, and resources to reduce new HIV infections by 75 percent in five years. Stigma is an enormous barrier to fighting HIV in the Deep South. The OHPC remains vigilant in supporting and promoting best practices that help reduce stigma and increase access to prevention and care services and other health resources. The EHA planning group utilizes sub-committees to research and implement state-wide strategies that promote inclusion, parity, and equity through advocacy and other capacity building efforts. The goal of the Committee is to build and strengthen collaborations among traditional and non-traditional HIV prevention and care providers, and leverage resources and expertise unique to individual CBOs and ASOs to end the HIV epidemic.

According to the CDC, "community engagement" is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources, influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices. The community engagement process is one of three steps in the CDC's HIV Community Planning process, which includes:

- Stakeholder Identification:
- Results-oriented engagement process; and
- Jurisdictional HIV prevention plan, development, implementation, and monitoring.

Recruitment flyers were also developed and distributed by email within the county health departments (CHDs) and to other Alabama CBOs. Prioritized populations were offered a seat at the EHE planning table. "Listening Sessions" with community stakeholders were indeed critical to the process. Sessions held prompted ADPH to:

- Convene focus groups in rural areas throughout the state.
- Set up recruitment booths at health fairs and conferences.
- Gain access to college campuses and other public institutions.

In late March 2020, safety concerns with the COVID-19 pandemic resulted in a change in recruitment plans. ADPH and Alabama Partners for Health, Inc. pivoted plans to work through current members' social and professional networks to recruit individuals to join the planning process using alternate platforms (i.e., Zoom meetings, Facebook, YouTube, conference calls). Developing relationships and encouraging participation among community members who have a stake in and support public health involves modeling certain "practice elements" (McCloskey et al1). The goal was to:

- Identify community members, key stakeholders, and resources.
- Develop strategies to facilitate information and ideas among community members, key stakeholders, and OHPC staff.
- Build and manage sustained formal and informal networks to strengthen relationships, communicate messages, and leverage resources.
- Empower community toward decision-making and social action. These "practice elements" were achieved by:
- Conducting both targeted and broad EHA recruitment.
- Consulting with established local advocacy groups, ASOs, and Linkage Specialists (peer advocates).
- Conducting a comprehensive needs assessment that included surveying, facilitating focus groups, and interviewing local HIV care providers.
- Coordinating regular monthly EHA planning and sub-committee meetings.

Recruitment

The team worked through social networks to recruit PWH, treatment providers, housing professionals, educators, social workers, counselors, tribal members, faith leaders, and community volunteers. As a planning committee, this group of diverse individuals meets monthly to share their collective wealth of experience through guided discussion across the four EHE pillars: diagnose, treat, prevent, and respond. Each month during data collection for the Jurisdictional Plan, discussion questions for the upcoming EHA meeting were sent out in advance to prepare members for discussion. EHA members were asked to invite other stakeholders to join meetings that might be of interest. Recruitment will continue and be enhanced by a special Membership sub-committee who will ensure that prioritized populations have continuous representation on the Committee. Prioritized populations in Alabama include PWH, people with trans experience, African Americans, Latinx people, MSM, and those who have unstable housing or are experiencing homelessness.

Consultation and Feedback

Throughout the community engagement process, the leadership team received feedback from community members that resulted in consultation with several individuals and community groups, including Latinx outreach workers, housing professionals, and LGBTQ and HIV advocacy groups. Consultation with community gatekeepers and stakeholders resulted in:

- English to Spanish translation of surveys, agendas, emails, and all other committee documents.
- Availability of a Spanish interpreter for EHE meetings.
- Provision of incentives for survey completion.
- Discussions with AIDS Alabama to assure accurate and relevant information about housing issues faced by PWH.
- Assistance with recruiting people with transgender experience from the Alabama chapter of the HRC and ADPH.

Information gathered from provider interviews, focus groups, surveys, and community meetings formed the Jurisdictional Plan. The charts below, organized by pillars, illustrate how needs assessment data and questions posed during monthly meetings provided community input for the 10 work plan strategies.

EPIDEMIOLOGY REPORT

The EHE plan has been created, implemented and evaluated in the context of the HIV/STD Epidemiological Profile 2018, with updated data from the 3rd quarter, 2020. The goal of the Initiative, according to the CDC, is that participant regions will "reach a 75% reduction in new HIV infections by 2025 and at least 90% reduction by 2030." Alabama is one of the seven states where rural areas have experienced a significant increase in cases.

Overview

The US Census Bureau estimates that in 2019 the population of Alabama reached 4,903,185 persons. As of September 2020, Preliminary Epidemiology Report for Alabama indicated that there were 361 newly diagnosed cases and 14,828 prevalent cases. Since 1982, when ADPH established HIV surveillance, 22,665 cases of HIV have been documented. If past projections hold, an additional 2,965 persons may be infected and unaware of their status.

Among Alabamians, 51.7 percent are female and 48.3 percent male. Census estimates find that 60.5 percent are between the ages of 18 and 65, 22.2 percent are under 18 years and 17.3 percent are older than 65. Most residents (69.1 percent) identify as White, while 26.8 percent identify as Black or African-American, 0.7 percent indicated that they were American Indian or Alaska Native, another 1.5 percent are Asian, and 1.8 percent identify as two or more races. Latinx-identified persons comprise 4.6 percent of the state.

Alabama's population can be divided into three geographical groupings: major urban centers (>200,000 population), minor urban centers (100,000-200,000 population), and rural areas (<100,000 population). Major urban centers include Jefferson, Madison, Mobile, and Montgomery counties. In 2017, these major urban centers represented 26.7 percent (1,299,798) of the state's total population and 55.8 percent (11,877) of cumulative HIV cases reported to ADPH. Alabama is considered primarily rural with 55 of its 67 counties located outside of the state's major and minor urban population centers.

According to the 2017 Alabama Poverty Data Sheet, Alabama is the sixth most poverty-stricken state in the nation. Eighteen percent of individuals residing in Alabama live below the federal poverty level. Another 14 percent of all families and 37 percent of families with a female head of household and no husband present have incomes below the poverty level. One-quarter (26 percent) of children less than 18 years and ten percent of the elderly aged 65 years and older live below the federal poverty level. The average personal income in Alabama is $25,746 and the median household income is $46,472.

The latest educational data is from the 2017 American Community Survey. The most common level of education attained in Alabama among people aged 25 years and older is a high school diploma or its equivalent (31 percent). While 22 percent of Alabama residents age 25 years and older report some college experience, only 15 percent successfully obtain a bachelor's degree or higher. Ten percent of residents age 25 years and older fail to graduate high school with five percent reporting less than a ninth-grade education. Assessing Alabama's four most populous counties (Jefferson, Madison, Mobile, and Montgomery Counties) with populations ranging from 229,363 in Montgomery County to 658,466 in Jefferson County shows roughly the same education distribution.

Alabama is divided into eight geographically distinct public health districts (PHDs) with the two most populous counties representing single PHDs (Figure 1). The remaining PHDs encompass 10 to 12 counties each. Four of Alabama's 19 Black Belt counties comprise the southwestern PHD. Each district has the authority to provide core public health services to the community including HIV counseling and testing, sexually transmitted disease (STD) screening and treatment, maternal and child health, vaccine-preventable immunizations, family planning, home health services, and adult health clinics.

Scope of the Epidemic

According to the 3rd quarter preliminary HIV data (January 1 through September 30) cited above, African-American/ Black persons are the most frequently noted group among newly-diagnosed (70.1 percent, n=253), prevalent (63.8 percent, n=9,467) and cumulative (63.9 percent, n=14,486) cases of HIV. The next most frequent group identifies as White: 24.1 percent (n=87) of newly-diagnosed; 27.3 percent (n=4,046) prevalent; and 29.3 percent (n=6,641) of cumulative cases. Across all three case classifications, the ratio of males to females approximates 3-1. Specifically, for newly-diagnosed persons males are 75.1 percent (n=271) and females 24.9 percent (n=90). Prevalent cases are 73.1 percent (n=10,846) males and 26.9 percent (n=3,982) are females. Males are 75.4 percent (n=17,099) of cumulative cases and 24.6 percent (n=5,566) are female.

Among the most noteworthy of the findings is the extent of the increase in infections among young people between the ages of 20 and 29. Although combined (20-24 and 25-29), that age group comprises only 12.1 percent (n=1,791) of prevalent cases, they are 36 percent (n=8,159) of cumulative cases and 41.5 percent (n=150) of the newly-diagnosed cases of HIV. Also of note is that new infections are most frequent among people who report heterosexual transmission (24.7 percent, n=88). Prevalent cases in this group are 29.8 percent (n=4,411) and 27.4 percent (n=6,165) of cumulative cases. For newly diagnosed cases, the highest percentage was for unknown or unreported risk. (51.7 percent, n=184). This was much higher than either prevalent cases (15.5 percent, n=2,3000) or cumulative cases (13.8 percent, n=3,106). Consistent through all categories of case reporting, the most frequently indicated risk in pediatric transmission was maternal infection (new diagnosis 80 percent, n=4; prevalence 80.8 percent, n=21; cumulative 86.6 percent, n=142)

Case Report by Health District

This section discusses HIV cases by PHDs. ADPH warns that these statistics should be interpreted with caution since not all reported cases have been entered into the HIV Surveillance database.

Specifically, ADPH notes that:

"Effective October 1, 2017, Public Health Areas have been redistributed as eight Public Health Districts. Unknown cases only accounted for the in-state total. To ensure statistically significant data, reported numbers less than 12, as well as estimated numbers (and accompanying rates and trends) based on these numbers, should be interpreted with caution because these numbers have underlying relative standard errors greater than 30% and are considered unreliable.

- Newly diagnosed HIV includes newly diagnosed HIV infections during the year of interest.
- Prevalent HIV includes all PWH as of September 30, 2020.
- Cumulative HIV includes all diagnosed HIV (living and deceased) as of September 30, 2020.
- Females with no risk factors reported are reclassified as heterosexual exposure.
- Age among newly diagnosed and cumulative cases is age at diagnosis. Prevalent age is the current age among cases living as of September 30, 2020.
- PHD represents residence at diagnosis among newly diagnosed and cumulative cases and current residence among prevalent cases.
- Current residence was updated in April 2015 and reflects cases that migrated to other states/jurisdictions. This accounts for recent decreases in prevalent cases.

PUBLIC HEALTH DISTRICT	PRELIMINARY 2020 - 3rd Quarter (January 1 - September 30)					
	Newly diagnosed		Prevalent Cases		Cumulative Cases	
	Cases	% of Total	Cases	% of Total	Cases	% of Total
Northern	40	13.0	1,686	11.4	2,228	9.9
East Central	68	22.1	2,920	19.7	4,727	21.0
West Central	31	10.1	1,029	7.0	1,432	6.4
Jefferson	59	19.2	3,936	26.6	6,093	27.1
Northeastern	27	8.8	1,327	9.0	1,605	7.1
Southeastern	25	8.1	1,089	7.4	1,559	6.9
Southwestern	12	3.9	791	5.3	1,248	5.6
Mobile	45	14.7	2,017	13.6	3,567	15.9
Total*	307	100.0	14,795	100.0	22,459	100.0

* (does not include "unknown")

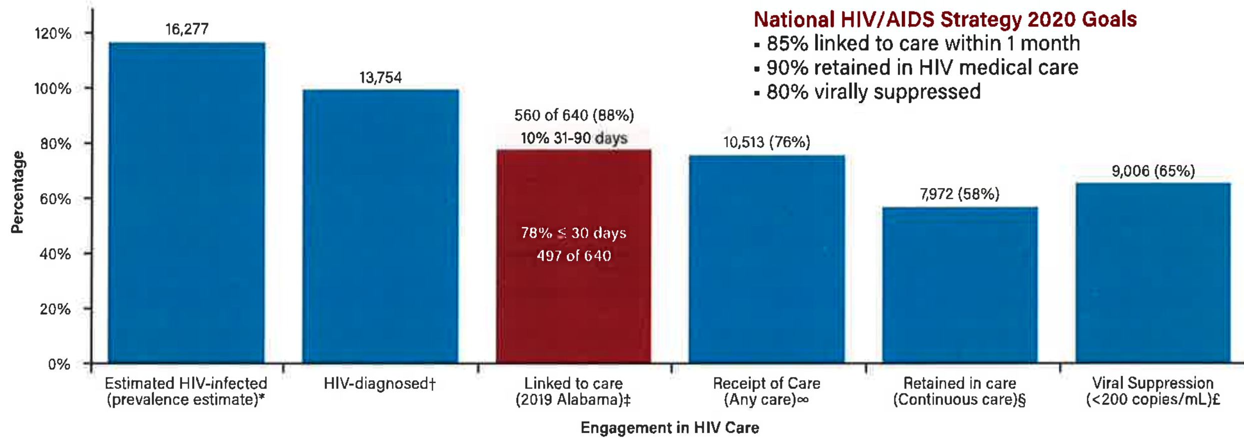
As seen above, the East Central district has the greatest percentage of cases (22.1 percent, n=68), surpassing the Jefferson County district, which has had the highest percentage in the prevalent (26.6 percent, n=3,936) and cumulative cases (27.1 percent, n=6,093). The East Central area includes the city of Montgomery and Lee county, home to Auburn University. For this reporting period, only Limestone and Madison, which are Northern district counties posted new cases. Madison includes the city of Huntsville and there is a prison system in Limestone county.

UA, with an enrollment of 37,824 is located in Tuscaloosa, part of the West Central PHD. The area reported 77.4 percent (n=24) of the newly-diagnosed cases in this timeframe. Previously, it was the area with the greatest frequency of cases (56.1 percent, n=577 of prevalent cases, 58.8 percent n=842 of cumulative cases), the percentage is higher in newly-diagnosed cases. Birmingham, the largest city in Alabama is in the Jefferson County district. Its case rate of 9.0, is lower than Mobile, but higher than Huntsville and more than four times higher than the overall state rate of newly diagnosed cases of HIV. The Northeastern district reported cases only in Calhoun and Shelby counties. A central Alabama area, Shelby County, is one of the fastest-growing in the state.

Houston county includes Dothan, the sixth-largest city in Alabama. It is the only region within the Southeastern district that reported new cases in 2020. It typically represents approximately one-third of the district's cases (36.6 percent, n=399 of prevalent cases and 33.2 percent, n=518), the recent proportion is much higher (48 percent, n=12). Although no new cases are reported in 2020, Baldwin county tends to be the community with the highest frequency of HIV cases within the Southwestern district. This region includes the coastal towns of Gulf Shores, Fairhope and Point Clear. Mobile is the third most populated city in Alabama. The rate of new cases is more than five-fold greater than the state as a whole.

HIV Treatment Cascade: AL Diagnosis-based HIV Care Continuum, 2019 Preliminary Data.

The next chart is excerpted from the ADPH report of the treatment cascade. These are preliminary 2019 data.
Note: Preliminary 2019 data should be interpreted with caution as not all reported cases have been investigated and entered into the HIV. Surveillance database; data will be finalized on December 31, 2020.



Alabama Diagnosis-based HIV Care Continuum, 2019 Preliminary Data Note:

Preliminary 2019 data should be interpreted with caution as not all reported cases have been investigated and entered into the HIV Surveillance database; data will be finalized on December 31, 2020. Alabama utilizes the National HIV Surveillance System diagnosis-based HIV care continuum methodology (i.e., the number of PWH is the denominator utilized for receipt of care, retained in care, and viral suppression). The prevalence estimate is shown in the first step as a percentage above 100 and is not utilized as the denominator for other steps in the care continuum.

* Prevalence includes both people whose infection has been diagnosed and those who are unaware of their infection (i.e., not yet diagnosed). Prevalence is estimated by applying Alabama's HIV-prevalence estimate (84.5%) to the number of PWH infection by the end of 2018 and living as of December 31, 2019 (i.e., 84.5% of persons aged ≥13 years living with HIV infection in Alabama are aware of their infection and 15.5%, or 1 in 6.5 HIV-positive individuals, are unaware of their infection). Source of Alabama's prevalence estimate: HIV Surveillance Report, Estimated HIV Incidence and Prevalence in the United States 2010-2016, Table 13. 2016 (most recent year available).

† Diagnosed measures the percentage of the total number of people living with HIV whose infection has been diagnosed. HIV-diagnosed is defined as the number of persons diagnosed with HIV infection by the end of 2018 and living as of December 31, 2019 (i.e., a person must be living with HIV for at least 12 months to measure progress along the HIV care continuum).

‡ Linked to care is calculated differently from other steps in the continuum and cannot be directly compared to other steps. Linked to care is calculated as the percentage of people receiving a diagnosis of HIV in a given calendar year (during 2019) who had ≥1 CD4 and/or viral load test within 30 days (1 month) of diagnosis. Although linked to care within 90 days (3 months) is no longer considered successful linkage to care, it is depicted for historical comparison.

∞ Receipt of medical care is defined as ≥1 test (CD4 or viral load). Receipt of care is calculated as the percentage of PWH who accessed **any** care during 2019, evidenced by ≥1 CD4, viral load, and/or HIV genotype test collected during 2019.

§ Retained in care is defined as ≥2 tests (CD4 or viral load) performed at least 3 months apart. Retention in care is calculated as the percentage of persons living with HIV who accessed **continuous** care during 2019, evidenced by ≥2 CD4, viral load, and/or HIV genotype tests collected at least 90 days apart during 2019.

£ Viral suppression is defined as <200 copies/mL on the most recent viral load test in 2019. Viral suppression is calculated as the percentage of PWH who had a suppressed viral load (<200 copies/mL) at the **last** viral load collected during 2019.

HIV CASES AMONG PERSONS RESIDING IN ALABAMA AT DIAGNOSIS

Preliminary 3rd Quarter 2020

CHARACTERISTIC	PRELIMINARY 2020 - 3rd Quarter (January 1 - September 30)					
	Newly Diagnosed		Prevalent Cases		Cumulative Cases	
Race/Ethnicity	Cases	% of Total	Cases	% of Total	Cases	% of Total
Black	253	70.1	9467	63.8	14486	63.9
White	87	24.1	4046	27.3	6641	29.3
Hispanic	11	3.0	481	3.2	511	2.3
Multi-race	5	1.4	734	5.0	894	3.9
Other/Unknown	5	1.4	100	0.7	133	0.6
Total	361	100.0	14828	100.0	22665	100.0

Gender	Cases	% of Total	Cases	% of Total	Cases	% of Total
Male	271	75.1	10846	73.1	17099	75.4
Female	90	24.9	3982	26.9	5566	24.6
Total (unknowns excluded)	361	100.0	14828	100.0	22665	100.0

Age (Years)	Cases	% of Total	Cases	% of Total	Cases	% of Total
<13	5	1.4	26	0.2	164	0.7
13-19	20	5.5	78	0.5	1136	5.0
20-24	77	21.3	507	3.4	3907	17.2
25-29	73	20.2	1284	8.7	4252	18.8
30-39	82	22.7	3130	21.1	6879	30.4
40-49	47	13.0	3127	21.1	3942	17.4
≥50	57	15.8	6676	45.0	2385	10.5
Total	361	100.0	14828	100.0	22665	100.0

Adult/Adolescent Exposure (≥13 years)	Cases	% of Total	Cases	% of Total	Cases	% of Total
MSM	76	21.3	6766	45.7	10044	44.6
Heterosexuals	88	24.7	4411	29.8	6165	27.4
Injection Drug Users (IDU)	3	0.8	746	5.0	1906	8.5
MSM/IDU	5	1.4	470	3.2	1171	5.2
Hemophilia/Coagulation Disorder	0	0.0	14	0.1	77	0.3
Mother with HIV Infection	0	0.0	91	0.6	0	0.0
Transfusion/Transplant Recipient	0	0.0	4	0.0	32	0.1
Risk Not Reported/Unknown	184	51.7	2300	15.5	3106	13.8
Total (add pediatric cases to total)	356	100	14802	100	22501	100.0

Pediatric Exposure (<13 years)	Cases	% of Total	Cases	% of Total	Cases	% of Total
Mother with HIV Infection	4	0	21	80.8	142	86.6
Hemophilia/Coagulation Disorder	0	0	0	0.0	7	4.3
Transfusion/Transplant Recipient	0	0	0	0.0	1	0.6
Risk Not Reported/Unknown	1	0	5	19.2	14	8.5
Total	5	0	26	100.0	164	100

Prevalent HIV Cases
Diagnosed and Living With HIV

Data Finalized as of 2021

Diagnosed and Living HIV Cases

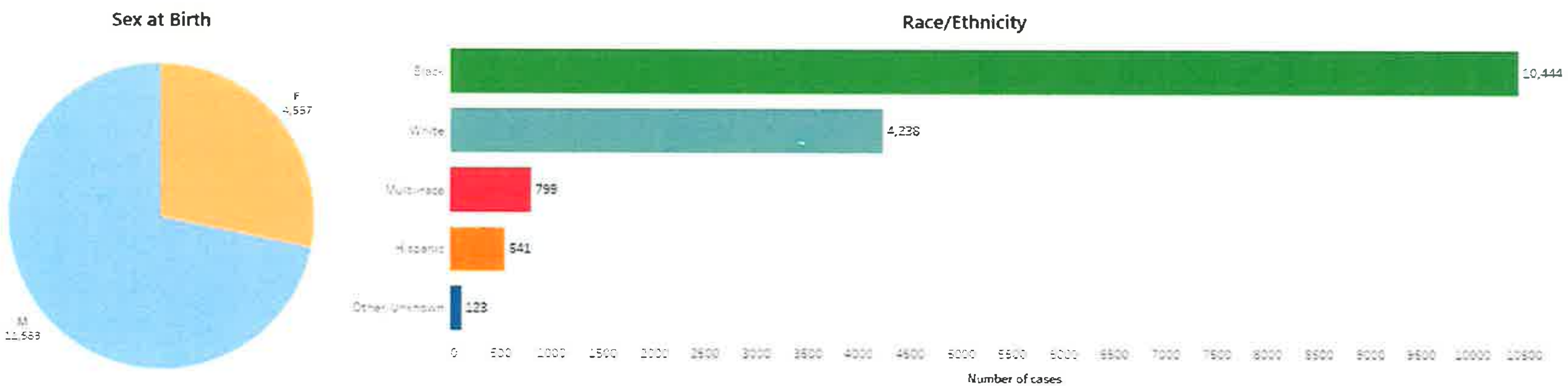
16,145

Sex at Birth

F 4,557

M 11,588

Race/Ethnicity



Filters

Sex at Birth
All

Race/Ethnicity
All

Current Age
All

Hover for Information

Hover for Definitions

Current Age

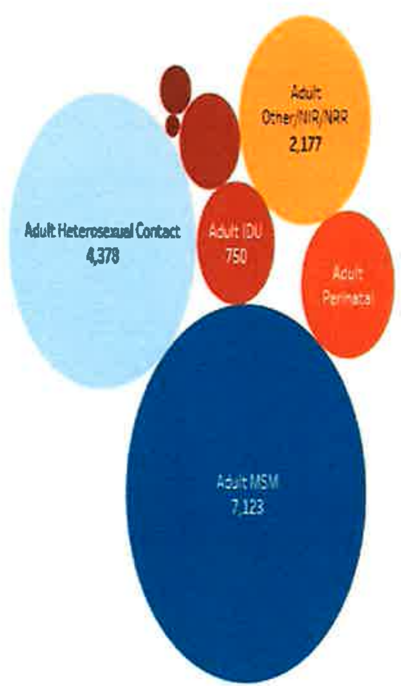
Age	Cases
0-12 years	372
13-19 years	318
20-29 years	2,212
30-39 years	3,326
40-49 years	3,115
>=50 years	6,802

Mode of Transmission

Data Finalized as of 2021

Sex at Birth

All



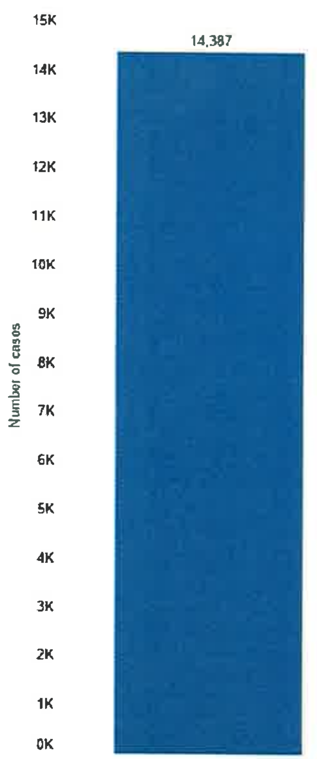
Acronyms

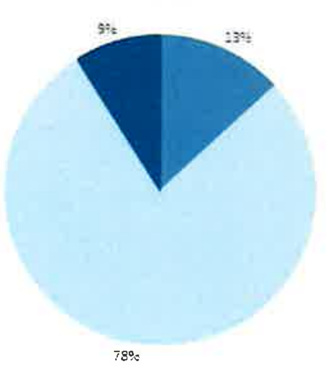
MSM: Men who have sex with men

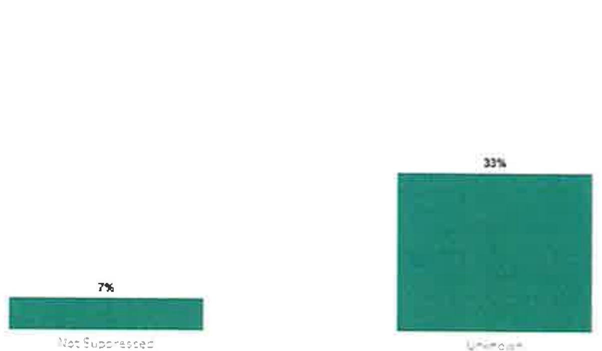
IDU: Injection drug users

NIR/NRR: No indicated risk/No risk reported

Alabama HIV Care Dynamics, 2021







Filters

Birth Sex
All

Race Eth
All

Prev Age
All

Mode
All

District
All

HIV Care Continuum Definitions

Hover for Information

b. HIV Prevention, Care and Treatment Resource Inventory

Name of Contractor	Street Address	City	State	Zip Code	Phone Number	EIN (Employer ID Number)	Core Medical Services	Support Services	Service Type-Codes
Health Services Center	608 Martin Luther King Drive	Hobson City	AL	3620 1	256-832-0100	63-0993592	Outpatient/Ambulatory Health Services; Oral Health Care; Health Insurance Premium and Cost Sharing; Mental Health Services	Medical Transportation Services	1a,1d, 1f, 1j, 2i
Health Services Center EC	608 Martin Luther King Drive	Hobson City	AL	3620 1	256-832-0100	63-0993592	Outpatient/Ambulatory Health Services; Oral Health Care	N/A	1a, 1d
Birmingham AIDS Outreach	205 32nd Street South #101	Birmingham	AL	3523 3	205-322-4197	63-0948495	Mental Health Services	Case Management (Non-Medical); Emergency Financial Assistance; Food Bank/Home-Delivered Meals; Legal Services; Medical Transportation Services	1j, 2a, 2c, 2d, 2g, 2i
Birmingham AIDS Outreach EC	205 32nd Street South #101	Birmingham	AL	3523 3	205-322-4197	63-0948495	AIDS Pharmaceutical Assistance (local); Mental Health Services	Case Management (Non-Medical); Emergency Financial Assistance; Food Bank/Home Delivered Meals; Legal Services; Medical Transportation Services	1b, 1j, 2a, 2c, 2d, 2g, 2i

Name of Contractor	Street Address	City	State	Zip Code	Phone Number	EIN (Employer ID Number)	Core Medical Services	Support Services	Service Type-Codes
AIDS Alabama	3521 7th Avenue South	Birmingham	AL	35222	205-324-9822	58-1727755	Health Insurance Premium & Cost Sharing Assistance; Mental Health Services; Substance Abuse Services-Outpatient	Case Management (Non-Medical); Emergency Financial Assistance	1f, 1j, 1m, 2a, 2c
UAB 1917 Clinic	908 20th Street South	Birmingham	AL	35294	205-934-1917	63-0649108	Outpatient/Ambulatory Health Services; Oral Health Care; Mental Health Services	N/A	1a, 1d, 1j
UAB 1917 Clinic EC	908 20th Street South	Birmingham	AL	35294	205-934-1917	63-0649108	Outpatient/Ambulatory Health Services	N/A	1a
UAB Family Clinic	1600 5th Avenue South, CPPI-G20	Birmingham	AL	35233	205-638-2337	1636005396A6	Outpatient/Ambulatory Health Services; AIDS Pharmaceutical Assistance (local); Oral Health Care; Early Intervention Services; Medical Case Management (including Treatment Adherence)	Case Management (Non-Medical); Health Education/Risk Reduction; Referral for Health Care/Supportive Services	1a, 1b, 1d, 1e, 1l, 2a, 2e, 2l
AIDS Action Coalition	600 St. Clair Avenue, Bldg 3	Huntsville	AL	35801	256-536-4700	57-0889447	Outpatient/Ambulatory Health Services; Oral Health Care; Medical Case Management (including Treatment Adherence)	Case Management (Non-Medical); Linguistics Services; Medical Transportation Services	1a, 1d, 1l, 2a, 2h, 2i

Name of Contractor	Street Address	City	State	Zip Code	Phone Number	EIN (Employer ID Number)	Core Medical Services	Support Services	Service Type-Codes
USA Family Clinic	1504 Springhill Avenue, Room 5225	Mobile	AL	36604	251-405-5344	63-0725648	Outpatient/Ambulatory Health Services; Oral Health Care	Medical Transportation Services	1a, 1d, 2i
Unity Wellness Center	122 N20th St Bldg #26	Auburn	AL	3608	334-749-3593	26-3644553	Outpatient/Ambulatory Health Services; Mental Health Services; Medical Case Management (including Treatment Adherence)	Medical Transportation Services	1a, 1j, 1l, 2e
Mobile County Health Dept	251 North Bayou Street	Mobile	AL	36603	251-690-8153	63-6001641	Outpatient/Ambulatory Health Services; Oral Health Care; Early Intervention Services; Mental Health Services; Substance Abuse Services-Outpatient	Health Education/Risk Reduction	1a, 1d, 1e, 1j, 1m, 2e
AIDS Alabama South	2054 Dauphin Street	Mobile	AL	36606	251-471-5277	46-2661900	Oral Health Care; Health Insurance Premium and Cost Sharing	Case Management (Non-Medical); Emergency Financial Assistance; Food Bank/Home-Delivered Meals; Medical Transportation Services	1d, 1f, 2a, 2c, 2d, 2i
Selma AIR	102 Park Place	Selma	AL	36701	334-872-6795	63-1133272	Oral Health Care; Medical Case Management (including Treatment Adherence)	Case Management (Non-Medical); Food Bank/Home-Delivered Meals; Psychosocial Support Services	1d, 1l, 2a, 2d, 2k

Name of Contractor	Street Address	City	State	Zip Code	Phone Number	EIN (Employer ID Number)	Core Medical Services	Support Services	Service Type-Codes
Franklin Primary Health	1303 Dr. Martin Luther King Jr Avenue	Mobile	AL	3660 3	251-432-4117	63-0695975	Outpatient/Ambulatory Health Services; AIDS Pharmaceutical Assistance (local); Health Insurance Premium and Cost Sharing; Mental Health Services; Medical Nutrition Therapy; Medical Case Management (including Treatment Adherence); Substance Abuse Services-Outpatient	N/A	1a, 1b, 1f, 1j, 1k, 1l, 1m
Five Horizons formerly known as West Alabama AIDS Outreach	2720 6th Street #100	Tuscaloosa	AL	3540 1	205-759-8470	63-0995963	Medical Case Management (including Treatment Adherence)	Case Management (Non-Medical); Emergency Financial Assistance; Food Bank/Home-Delivered Meals; Medical Transportation Services; Psychosocial Support Services	1l, 2a, 2c, 2d, 2i, 2k
Whatley Health Services	2731 Martin Luther King Jr Boulevard	Tuscaloosa	AL	3540 1	205-758-6647	63-0727781	Outpatient/Ambulatory Health Services; Oral Health Care; Health Insurance Premium and Cost Sharing; Mental Health Services; Medical Nutrition Therapy	Emergency Financial Assistance; Health Education/Risk Reduction; Medical Transportation Services; Treatment Adherence Counseling	1a, 1d, 1f, 1j, 1k, 2c, 2e, 2i, 2p

Provider Interview Guide

- ***General guidelines***
  - Many of the questions will be the same as those in the interview guide
  - These questions will focus on community acceptance and suggestions for strategies
  - The phrasing of the questions avoids use of jargon
  - In order to compare community vs provider responses, we will continue to focus on the following:
    - What exists now?
    - What should be?
    - What are the barriers to what should be?
    - What could facilitate improved model?
    - What suggestions do you have that would enable the state to achieve the EHE goals?

FOCUS GROUP GUIDE	
GENERAL QUESTIONS	
✳ Introductions	✳ Include affiliations
✳ Background	✳ What brings you here today? ✳ What would you like to accomplish?
✳ General knowledge	✳ How serious a problem is HIV in Alabama, especially your community? ✳ What puts people at risk for HIV? ✳ In general, how effective is your community in addressing HIV? ✳ What do you believe is the role of ADPH in addressing HIV?
DIAGNOSE	
OUTCOME	**QUESTIONS**
✳ Increased routine opt-out HIV screening	✳ What do you know about opt-out screening? (Explain, as needed) ✳ Is opt-out screening a good idea? ✳ Would your community favor opt-out screening? ✳ why or why not? ✳ What would make it difficult to implement opt-out screening? ✳ How might opt-out screening work in your community? ✳ Is there an alternative to opt-out screening that would increase testing among those at risk for HIV?
✳ Increased local availability of, and accessibility to HIV testing services	✳ Where do people in your community get HIV tests? ✳ How do people in your community find out about HIV test sites? ✳ Are you aware of any efforts in your community to promote HIV testing? ✳ Are there an adequate number of HIV test sites in your community? ✳ What information do people in your community need to know about HIV test sites? ✳ What prevents people from using the current HIV test sites?

∗ Increased HIV screening and re-screening among persons at elevated risk for HIV	∗ What behaviors put people at risk for contracting HIV? ∗ How do people in your community determine if they should be tested for HIV? ∗ What prevents people from getting tested for HIV? ∗ Is there a stigma attached to HIV testing in your community? ∗ What have you heard about the experience of people who try to get tested for HIV? ∗ What do you suggest to increase HIV testing rates for those who need test?
∗ Increased knowledge of HIV status	∗ What would make it easier for people to know their HIV status? ∗ What would motivate those at risk to be tested? ∗ What might be effective strategies to encourage people to get tested that you have seen? ∗ What prevents people from being tested for HIV?
∗ Reduced new HIV diagnoses	∗ What would be the most effective ways to reduce new HIV infections? ∗ Who should be receiving information about HIV prevention? ∗ What would be effective ways to get information about HIV prevention to those who need it? ∗ What have we not discussed that you would like to talk about?

TREAT	
OUTCOME	**QUESTIONS**
∗ Increased rapid linkage to HIV medical care	∗ Where do you think that newly-diagnosed people typically seek care for HIV? ∗ What problems do people have in getting medical care for HIV? ∗ What helps people newly-diagnosed begin medical care for the infection? ∗ Where should people with HIV be able to get care?
∗ Increased early initiation of ART	∗ What do you know about Antiretroviral Therapy (ART)? (Explain as needed) ∗ Do you think all people with HIV should be able to get ART? ∗ What would help people continue ART? ∗ What prevents people from being able to get ART? ∗ What would make it easier for people with HIV to access ART?
∗ Increased immediate re-engagement to HIV prevention and treatment services for PWH who have disengaged from care	∗ Does your community have enough resources to enable people with HIV to receive HIV-related medical care?

<table>
<tr><td>* Increased receipt of HIV medical care among PWH</td><td>* Does your community have enough resources to enable people with HIV to receive general medical care?
* Sometimes people discontinue medical care for HIV, even though they need it. What in your community supports people to continue care?
* Is there any strategies that you believe would successfully get patients back into care?</td></tr>
<tr><td>* Increased viral suppression among PWH</td><td>* What do you know about the impact of “viral suppression” on the health of the individual with HIV and on their likelihood of being able to infect someone else?
* Do you think that there are other services that would help people with HIV stay healthy?
* Do you have any other thoughts about what people with HIV need to stay healthy
* How concerned are you about the possibility that HIV rates will continue to rise in Alabama?</td></tr>
<tr><th colspan="2">PREVENT</th></tr>
<tr><th>OUTCOME</th><th>QUESTIONS</th></tr>
<tr><td>* Increased screening for PrEP indications among HIV-negative clients</td><td rowspan="2">* What do you know about PrEP? (Explain as needed)
* How do people in your community find out about PrEP?
* Do you think that people at risk for HIV should have access to PrEP?
* Who should be offering PrEP services?
* Who do you believe would be eligible for PrEP services?
* Are there enough clinics or other medical service agencies that provide PrEP?</td></tr>
<tr><td>* Increased referral and rapid linkage of persons with indications for PrEP</td></tr>
<tr><td>* Increased access to SSPs</td><td>* Explain SSP
* Is SSP screening a good idea?
* Would your community favor SSP?
  * why or why not?
* What would make it difficult to implement SSP?
* How might SSP work in your community?
* Is there an alternative to SSP that would decrease the risk for contracting HIV?</td></tr>
<tr><td>* Increased PrEP prescriptions among persons with indications for PrEP</td><td>* covered above</td></tr>
<tr><td>* Increased knowledge about the evidence-base of SSPs in communities</td><td>* Do you think that there should be changes in the law to enable Alabama to legalize SSP?</td></tr>
</table>

* Increased quality of evidence-based SSP service delivery	* How might an SSP work in Alabama?
RESPOND	
OUTCOME	**QUESTIONS**
* Increased health department and community engagement for cluster detection and response * Improved surveillance data for real time cluster detection and response * Improved policies and funding mechanisms to respond to and contain HIV clusters and outbreaks * Improved response to HIV transmission clusters and outbreaks	* What ADPH strategies would assist your community in identifying and responding to clusters? * What community strategies could your community enact to assist ADPH in identifying and responding to clusters? * What funding policies should be undertaken for response to clusters and outbreaks?

Data Collection Plan			
Source of Information	**Method**	**Instrument**	**Number**
Providers	☒ Telephone interviews	☒ Interview guide	18
PWH	☒ Surveys ☒ Focus groups	☒ PWA survey form ☒ Focus group guide	200
Persons At-Risk	☒ Surveys ☒ Focus groups	☒ Risk survey form ☒ Focus group guide	1,000
Community Stakeholders	☒ Focus groups	☒ Focus group guide	TBD

Provider Interview Guide

- General guidelines
  - We will be asking questions that elicit the following information:
    - What exists now?
    - What should be?
    - What are the barriers to what should be?
    - What could facilitate improved model?
    - What suggestions do you have that would enable the state to achieve the EHE goals?

PROVIDER INTERVIEW GUIDE	
DIAGNOSE	
OUTCOME	QUESTIONS
☀ Increased routine opt-out HIV screening	☀ What do you you know about opt-out screening? ☀ Is opt-out screening a good idea? ☀ Would your agency favor opt-out screening? ☀ why or why not? ☀ What would be barriers to implementing opt-out screening? ☀ What would allow agencies that are not in favor to adopt the practice ☀ Is there an alternative to opt-out screening that would increase testing among those at risk for HIV?
☀ Increased local availability of, and accessibility to HIV testing services	☀ Where do people in your community get HIV tests? ☀ How do people in your community find out about HIV test sites? ☀ Is there a coordinated campaign within the healthcare community that promotes HIV testing? ☀ Are there an adequate number of HIV test sites in your community? ☀ What information do people in your community need to know about HIV test sites? ☀ What prevents people from using the current HIV test sites?
☀ Increased HIV screening and re-screening among persons at elevated risk for HIV	☀ How do people in your community determine if they should be tested for HIV? ☀ What prevents people from getting tested for HIV? ☀ Is there a stigma attached to HIV testing in your community? ☀ What do your patients tell you about accessing HIV tests? ☀ What do you suggest to increase HIV testing rates for those who need test?
☀ Increased knowledge of HIV status	☀ In your opinion, what percentage of HIV positive persons know of their status? ☀ change in that over the past 12 months ☀ What would make it easier for people to know their HIV status? ☀ What would motivate those at risk to be tested? ☀ What have been the most effective strategies to encourage people to get tested that you have seen? ☀ What strategies would be successful in getting your most resistant client to be tested?

☒ Reduced new HIV diagnoses	☒ What would be the most effective interventions to reduce new HIV infections? ☒ What are the factors that are undermining efforts to reduce HIV infections? ☒ What populations are most at risk? Why? ☒ What have we not discussed that you would like to talk about?
TREAT	
OUTCOME	**QUESTIONS**
☒ Increased rapid linkage to HIV medical care	☒ On average, about how long does it take for most people newly-diagnosed with HIV to receive medical care? ☒ Where do newly-diagnosed people typically seek care for HIV? ☒ What are the barriers to accessing care? ☒ What helps people newly-diagnosed begin medical care for the infection? ☒ What other sites of medical care would you like to see offering services to people newly-diagnosed with HIV?
☒ Increased early initiation of ART	☒ In your agency, what is the typical time interval between diagnosis and initiation of ART? ☒ What reactions to patients have to discussion of initiation of ART? ☒ How compliant are your patients typically to the ART regimen? ☒ What are the barriers, if any, that your agency encounters in initiating ART for patients? ☒ What barriers do clients face in initiating ART? ☒ What would make it easier for patients to access ART?
☒ Increased immediate re-engagement to HIV prevention and treatment services for PWH who have disengaged from care	☒ In general, what percentage of your patients are lost to care? ☒ What strategies does your or other agencies use to get those out of care, back into treatment? ☒ How successful are these strategies? ☒ What reasons do your patients give for suspending medical care? ☒ What patient factors predict for you who might disengage from medical care? ☒ Is there any strategy that you would like to implement that you believe would successfully get patients back into care?
☒ Increased receipt of HIV medical care among PWH	☒ Does your agency have a specific system for tracking patients who may have disengaged in care? ☒ Does your agency have a formal process for following up with disengage patients? ☒ What strategies have you employed or seen that are particularly successful?

Increased viral suppression among PWH	What are the most important components of medical care to assure viral suppression among your patients with HIV?
PREVENT	
OUTCOME	**QUESTIONS**
Increased screening for PrEP indications among HIV-negative clients	How does your agency gain access to HIV-negative patients who might be eligible for PrEP? What additional strategies would you like to implement to gain access to HIV-negative patients who may be eligible for PrEP? What criteria do you use to determine who is PrEp eligible? How to your clients typically respond when PrEp is suggested?
Increased referral and rapid linkage of persons with indications for PrEP	Does your agency provide prescriptions for PrEP? How effective is the referral network for persons with PrEP indications? What is the approximate percentage of people with PrEP indications initiate treatment? Do patients tend to present for treatment, when referred? How successful are attempts to assure that patients on PrEP maintain compliance?
Increased access to SSPs	
Increased PrEP prescriptions among persons with indications for PrEP	Do you believe that all of those who have indication for PrEP are offered prescriptions? If not, what is preventing them for being prescribed PrEP
Increased knowledge about the evidence-base of SSPs in communities	What is your opinion of the Syringe Services Program? Do your patients request SSP? What are the objections raised in the community about SP? What would make SSP acceptable to the community? What legislative efforts might be effective in adopting SSP?
Increased quality of evidence-based SSP service delivery	How might an SSP work in Alabama?
RESPOND	

OUTCOME	QUESTIONS
✳ Increased health department and community engagement for cluster detection and response ✳ Improved surveillance data for real time cluster detection and response ✳ Improved policies and funding mechanisms to respond to and contain HIV clusters and outbreaks ✳ Improved response to HIV transmission clusters and outbreaks	✳ What ADPH strategies would assist your community in identifying and responding to clusters? ✳ What community strategies could your community enact to assist ADPH in identifying and responding to clusters? ✳ What funding policies should be undertaken for response to clusters and outbreaks?

Ending the HIV Epidemic Project Survey

Welcome

Thank you for choosing to participate in the survey conducted by the Alabama Partners for Health, Inc.

Our goal is to try to improve services to people who have HIV. Your opinions are very important to this effort.

All of your responses are confidential and will not affect your ability to get care.

The survey takes about 15-20 minutes to complete. You do not need to finish all at once but can go back as many times as you would like to complete it. You can do this until April 30.

Thank you again for your help!

Ending the HIV Epidemic Project Survey

About you

1. What year were you born?

2. In what type of area do you live?

- Urban (in a city)
- Suburban (outside a city)
- Rural (in the country)
- I move around or am homeless

3. How would you describe yourself? (Please check all that apply)

- American Indian or Alaska Native
- Asian or Asian American
- Black or African American
- Native Hawaiian or other Pacific Islander
- White or Caucasian
- Multiracial
- Prefer not to answer

4. Are you Hispanic or Latino?

- Yes
- No

5. What language do you prefer your healthcare provider uses?

6. What sex were you assigned at birth?

- Female
- Male

7. What is your current sex/gender?

8. What is your sexual orientation?

9. What is your relationship status?

- Single/living alone
- Married
- Living with partner
- Divorced/separated
- Widowed
- Other (please specify)

10. What is your highest level of education?

- Less than high school
- High school graduate
- Some technical school
- Technical school graduate
- Some college
- College graduate
- Some post-graduate
- Graduate or advanced degree

11. Do you have insurance coverage with any of the following? (please include all types)

- Medicaid
- Medicare
- Private insurance from an employer
- Private insurance not from an employer
- Tri-care
- Veterans' Administration (other military coverage)
- No insurance
- Other (please specify)

12. What is your approximate yearly income? (please include all sources)

- $0-$9,999
- $10,000 and $29,999
- $30,000 and $49,999
- $50,000 or more

13. Where do you get your income? (please select all sources)

- Full time job
- Part time job
- Odd jobs/occasional work
- Partner
- Parents
- Other (please specify)
- Other family
- Friends
- Disability income (SSDI)
- SSI
- Refund check from school financial aid

14. What is your housing situation?

- Own a house
- Rent an apartment or house
- Residential treatment program
- Temporary or transitional housing
- Living temporarily with a friend or family
- Living permanently with a friend or family
- Live in a shelter
- VA-supported housing
- Homeless

15. I live (with)... (please check all that apply)

- Alone
- Spouse/partner
- Children
- Parents
- Other family
- Friends
- Roommate
- Other (please specify)

16. How stable do you believe your housing status is?

- Very stable
- Stable
- Neutral
- Other (please specify)
- Unstable
- Very unstable

17. How often do you run out of food before you have money to buy more?

- Almost always
- Usually
- Sometimes
- Rarely
- Never

18. How often are you limited in where you can go because of transportation?

- Almost always
- Usually
- Sometimes
- Rarely
- Never

Health Status

19. How do you rate your overall health?

- Excellent
- Good
- Neutral
- Fair
- Poor

20. Please indicate how often you use the following:

	Daily	Several times a week	Weekly	Several times a month	Monthly	A few times a year	Never
Alcohol							
Cocaine (powder)							
Crack							
Heroin							
LSD (acid)							
Marijuana							
Methamphetamine (Meth)							
Mushrooms (psylocibin)							
Prescription drugs (not prescribed to you)							

21. Do you now or have you in the past injected drugs that were not prescribed for you?

- Yes, in the past but not now
- Yes, use currently
- No

22. Have you received treatment for drug use?

- Yes
- No

23. Have you received psychotherapy for an emotional health disorder?

Ye

s

No

24. Have you taken prescription medication for an emotional health disorder?

Yes

No

25. Please indicate which of the following you do to protect yourself and potential partners from HIV infection/reinfection. (please check all that apply)

Get tested and treated for sexually-transmitted infections

Use condoms

Know partner's HIV status

Use PrEP

Limit number of sex partners

Do not inject drugs

Other (please specify)

26. Please indicate if you have been diagnosed by a health care provider with any of the following medical conditions (please check all that apply)

Arthritis

Hepatitis C

Asthma

High blood pressure

Autoimmune disease

HIV

Cancer

Insulin resistance (pre-diabetes)

Diabetes

Neurological disease

Heart disease

Mental health disorder

Hepatitis B

Substance use disorder

Other (please specify)

HIV-related

27. In what year were you first diagnosed with HIV?

28. Why did you decide to be tested for HIV? (please check all that apply)

- A health care provider recommended it
- I had unprotected sex and did not know the HIV status of my partner
- I had unprotected sex with someone who may have been HIV positive
- A health department representative told me that a person with whom I had sex or exchanged needles had tested positive
- I shared needles, syringes or other injection drug equipment
- I was tested when I went to the emergency room or hospital for some other reason
- Other (please specify)
- I was tested as part of pregnancy care
- I was tested when I was donating blood or plasma
- As part of taking care of my health, I thought it was a good idea to be tested
- I was feeling sick and decided to get tested
- A friend or family member encouraged me to be tested

29. After you tested positive for HIV, which of the following occurred next? (please check all that apply)

- An appointment with the Health Department or clinic was made for me
- I was told where to go for HIV care
- Professional staff member or peer went with me to a medical care appointment
- Other (please specify)

30. How long after you were diagnosed did you see a health care provider for HIV care?

- 1-30 days
- 31-60 days
- More than 90 days
- Other (please specify)

31. What was your insurance status at the time you first received medical care for HIV? (please check all that apply)

- Had insurance through work
- Medicare
- Medicaid
- Tri-care, VA (or other military health care_
- ACA exchanges
- No insurance

32. When have you received the following services for HIV care? (please check all that apply)

	At diagnosis	Currently	Never
Assistance with health insurance			
Case management/social worker			
Dental care			
Eligibility services			
Emergency financial assistance (utilities and housing)			
Food bank/food vouchers			
Health education/risk reduction			
HIV medical care			
HIV/AIDS medication			
Housing assistance			
Language interpretation services			
Medical nutrition services (met with dietician)			
Mental health care			
Substance use treatment			
Support groups			
Transportation			

33. Please indicate your experience with the following health services.

	Knew about the service, but did not need it	Received satisfactory service	Needed service, but DID NOT receive service	Received service and it DID NOT MEET my needs	Not applicable
Access to medication					
Dental care					
Home health					
Medical case management					
Medication assistance					
PrEP					
Primary medical care					
Specialty medical care					

34. Please indicate your experience with the following counseling services.

	Knew about the service, but did not need it	Received satisfactory service	Needed service, but DID NOT receive service	Received service and it DID NOT MEET my needs	Not applicable
Crisis or emergency counseling					
Group mental health counseling					
Individual mental health counseling					
Peer support group					
Psychological support counseling					
Peer counseling and support for substance use treatment					
Outpatient substance use counseling					
24 hour-a-day residential substance use counseling					
Peer counseling and support for substance use treatment					
Outpatient substance use counseling					
24 hour-a-day residential substance use counseling					

Other (please specify)

35. Please indicate your experience with the following support services.

	Knew about the service, but did not need it	Received satisfactory service	Needed service, but DID NOT receive service	Received service and it DID NOT MEET my needs	Not applicable
Bi-lingual forms and services					
Childcare					
Emergency financial assistance					
Employment assistance					
Financial support					
Food-related services					
Health insurance					
HIV education/risk reduction					
Housing					
Information on HIV services					
Legal services					
Medical and treatment adherence support					
Medical marijuana					
Non-medical case management					
Patient advocates					
Referral to health care/support services					
Services for immigrants/undocumented persons					

36. How helpful are of the services you received for starting and staying in care for HIV?

	Helped to start treatment	Helped to stay in care	Not helpful	Do not use this
Assistance with health insurance				
Case management/social worker				
Dental care				
Eligibility services				
Emergency financial assistance (utilities and housing)				
Food bank/food vouchers				
Health education/risk reduction				
HIV medical care				
HIV/AIDS medication				
Housing assistance				
Language interpretation services				
Medical nutrition services (met with dietician)				
Mental health care				
Substance use treatment				
Support groups				
Transportation				

37. How easy or difficult is it to access the services?

	Easy	Neutral	Difficult	Do not use
Assistance with health insurance				
Case management/social worker				
Dental care				
Eligibility services				
Emergency financial assistance (utilities and housing)				
Food bank/food vouchers				
Health education/risk reduction				
HIV medical care				
HIV/AIDS medication				
Housing assistance				
Language interpretation services				
Medical nutrition services (met with dietician)				
Mental health care				
Substance use treatment				
Support groups				
Transportation				

Other (please specify)

38. Has there been a time of 12 months or more when you did not receive care related to HIV/AIDS?

Yes

No

Staying in HIV care

39. Have you come up against any of these challenges to getting HIV care. (please check all that apply)

- Cost too much
- Could not get appointment
- Did not feel sick
- Did not know where to get services
- Did not qualify
- Fear of medication side effects
- Housing problems
- Inconvenient appointment times
- Alcohol or drug use
- Language/culture barriers
- Long wait time for services
- No child care
- No insurance
- No reliable transportation
- Services too far away
- Not ready to deal with HIV
- Too busy
- Was homeless
- Was in jail or prison
- Work-related issues
- Was not comfortable with provider
- Other (please specify)

40. What enabled you to overcome those barriers to getting HIV/AIDS-related care? (please check all that apply)

- ~~I was ready to deal with my HIV status~~
- I was able to deal with other things I worried about
- I got sick and needed to get back into care
- I got the information that I needed to convince me to get care
- I found a doctor or medical facility that I liked
- Someone working in an HIV-related care contacted me and convinced me to get care
- I found housing
- I got out of jail/prison
- Substance use issues got better
- I was able to get insurance
- Found services that I could afford
- Was able to get an appointment
- Got transportation
- Found providers that offered services that worked with my culture/language
- Found services closer to where I live or work
- Work problems were worked out

Your comments

41. Are there any other HIV-related services the you need, but cannot get or are not offered in your area?

42. What concerns do you have about getting care or treatment services in the future?

43. Is there anything else that you would like to add about your needs, gaps in what services you can get or the barriers that you have experienced in getting HIV/AIDS care and support services?

Welcome!

Thank you for choosing to respond to this survey conducted by the Alabama Partners for Health, Inc. Our goal is to try to improve services that help people prevent HIV. Your opinions are very important to this effort.

The survey takes about 15-20 minutes to complete. You do not need to finish all at once but can go back as many times as you would like to complete it. You can do this until April 30.

All of your responses are confidential and will not affect your ability to get care.

Thank you again for your assistance!

About You

1. What year were you born?

2. What is your zip code?

3. In what type of area do you live?

- Urban (in a city)
- Suburban (outside a city)
- Rural (in the country)
- I move around or am homeless
- Other (please specify)

4. How would you describe yourself?

- American Indian or Alaska Native
- Asian or Asian American
- Black or African American
- Native Hawaiian or other Pacific Islander
- White or Caucasian
- Multiracial
- None of the above
- Prefer not to answer

5. Are you Hispanic or Latino?

- Yes
- No

6. What sex/gender were you assigned at birth?

- Female
- Male

Other (please specify)

7. What is your current sex/gender?

8. What is your sexual orientation?

9. What is your relationship status?

- Single/living alone
- Married
- Living with partner
- Other (please specify)
- Divorced/separated
- Widowed

10. What is your highest level of education?

- Less than high school
- High school graduate
- Some technical school
- Technical school graduate
- Some college
- College graduate
- Some post-graduate
- Graduate or advanced degree

11. Do you have insurance coverage with any of the following? (please include all types that you have)

- Medicaid
- Medicare
- Private insurance through employer
- Private insurance, not from an employer
- Tri-care
- Veterans' Administration (other military coverage)
- Insurance through ACA exchanges
- No insurance
- Don't know

12. What is your approximate yearly income? (please include all sources)

- $0-$9,999
- $10,000-$19,999
- $20,000 and $29,999
- $30,000 and $49,999
- $50,000 and $74,999
- $75,000 or greater

13. What language do you prefer your healthcare provider uses?

14. Where do you get your income? (Please check all that apply)

- Full time job
- Part time job
- Odd jobs/occasional work
- Partner
- Parents
- Other (please specify)
- Other family
- Friends
- Disability income (SSDI)
- SSI
- Refund check from college financial aid

15. What is your housing situation?

- Own a house
- Rent an apartment or house
- Residential treatment program
- Temporary or transitional housing
- Living temporarily with friend or family
- Other (please specify)
- Living permanently with friend or family
- Living in a shelter
- VA-supported housing
- Homeless

16. I live (with)... (please check all that apply)

- Alone
- Spouse/Partner
- Children
- Parents
- Other family
- Friends
- Roommate
- Other (please specify)

17. How stable do you believe your housing status is?

- Very stable
- Stable
- Neutral
- Unstable
- Very unstable

18. How often do you worry that you will run out of food before you have money to buy more?

- Always
- Usually
- Sometimes
- Rarely
- Never

19. How often do you run out of food before you have money to buy more?

- Almost always
- Usually
- Sometimes
- Rarely
- Never

20. How often are you limited in where you can go because of transportation?

- Almost always
- Usually
- Sometimes
- Rarely
- Never

21. What types of transportation do you most often use? (please check all that apply)

- Own car
- Get a ride from a family member
- Get a ride from a friend
- Bus
- Uber, Lyft or other ride share
- Taxi
- Walk or bike

Health Status

22. In general, how would you rate your overall health?

- Excellent
- Very good
- Good
- Fair
- Poor

23. Compared to last year, how would you rate your health?

- Much better
- Better
- About the same
- Worse
- Much worse

24. Please indicate how often you use the following:

	Daily	Several time a week	Weekly	Several time a month	Monthly	Few times a year	Never
Alcohol							
Cocaine (powder)							
Crack							
Heroin							
LSD (acid)							
Marijuana							
Methamphetamine (Meth)							
Mushrooms (psylocibin)							
Prescription drugs (not prescribed for you)							

Other (please specify)

25. Do you now or have you in the past injected drugs that were not prescribed for you?

Yes, in the past, but not now

Yes, currently using

No

26. Are you currently receiving treatment for drug use?

Yes

No

27. Have you received treatment for drug use *in the past* (do not include current treatment)?

Yes

No

28. Are you currently receiving psychotherapy/counseling for an emotional health disorder?

Yes

No

29. Are you currently taking prescription medication for an emotional health disorder?

Yes

No

30. Have you taken prescription medication for an emotional health disorder in the past (do not include current treatment)?

Yes

No

31. Please indicate which of the following you do to protect yourself from HIV and other sexually transmitted infections. (Please check all that apply)

Get tested for HIV

Get tested and treated for sexually-transmitted infections

Know sex partner's HIV status

Limit number of sex partners Use condoms

Use PrEP

Other (please specify)

32. Please indicate if you have been diagnosed by a health care provider with any of the following medical conditions

Arthritis
Asthma
Cancer
Diabetes
Heart disease
Hepatitis C
High blood pressure
Sexually-transmitted infection
Other (please specify)

33. Please indicate if you have been diagnosed by a health care provider with any of the following mental health conditions

Anxiety disorder
Autism
Bi-polar disorder
Depression
Obsessive-compulsive disorder
Schizophrenia
Substance use disorder
Other (please specify)

34. Please indicate your experience with the following services. (Please check all that apply)

	Knew about the service	Received satisfactory service	Needed, but did not receive service	Received service, but did not help	Not applicable
Hepatitis B testing/Vaccinations					
Hepatitis C testing/Vaccinations					
HIV testing					
HIV/STD Health Education					
Individual HIV-related prevention education					
Language/cultural appropriate services					
Mental health counseling					
Partner services					
Pharmacy/Medication services					
PrEP or nPEP					
Primary medical care					
STD testing					
Substance use treatment					
Syringe (needle) exchange					

35. Please tell us which of the following have, or might affect your ability to get health care or mental health care services

- Afraid of what others would think (stigma)
- Cost of services
- Cultural/language barriers
- Did not know where to go for services
- Do not need services
- Do not want services
- Drugs or alcohol use
- Feared being judged by medical provider
- Had to wait too long for service
- Other (please specify)
- Needed evening appointment
- Needed weekend appointment
- No child care
- No health insurance
- No reliable transportation
- Other health problems
- Services too far from where I work or live
- Too busy

36. Is there anything else you would like to suggest that would help you get health care services?

SITUATIONAL ANALYSIS

Efforts to end the HIV epidemic have been conducted for nearly 40 years. The implementation of new strategies has resulted in remarkable progress in core public health, healthcare, mental healthcare and prevention sciences. However, the number of HIV cases continues to rise from relatively low but consistent rates in some regions to alarmingly high rates in outbreaks in others.

One of the most recent strategies toward the goal of eliminating HIV is the EHE Initiative, a national collaborative response developed and embraced by the CDC, Health Resources and Services Administration, Indian Health Service, National Institute of Health, Office of the Assistant Secretary for Health and the Substance Abuse and Mental Health Services Administration. Successful implementation of EHE is based on the following topics with recommended strategies and outcomes in four categories: prevention, diagnosis, treatment, and response.

ADPH oversees the statewide planning and implementation of the EHE initiative. Implementation began when Dr. Scott Harris, State Health Officer, convened an EHE Leadership Team that included Dr. Mary McIntyre, Chief Medical Officer, OHPC staff, and leaders from ASOs. To ensure the strategies are effective and relevant to the communities wherein they will be enacted, ADPH established an EPC of statewide stakeholders who will participate in every phase of developing a strategic plan to meet the requirements of the EHE initiative.

A first step in the EHE strategic plan development process was the commissioning of a comprehensive needs assessment. This document is a brief excerpt from that needs assessment, which supports all assertions with qualitative and quantitative data. Due to the exigencies of the COVID-19 pandemic, initial plans for data collection methods were revised. Information was gathered in English and Spanish through electronic surveys, telephone interviews, and virtual focus groups. **Several overarching themes emerged from these: stigma, education, lack of resources, and cultural considerations.**

STIGMA

Every participant in each of the groups and interviews, regardless of the topic of discussion, asserted—often with great passion—the power that stigma had on inhibiting prevention, diagnosis, treatment, and the community response to HIV. They defined it as an internalized factor in clients with HIV and those at risk, as well as a response to them by the community-at-large and even some healthcare providers. The internalized stigma was described as a sense of shame for an identity that characterized the person with HIV as "immoral," "dirty" and "sinful." Participants described their clients as struggling with initiating or maintaining care since doing so, they worried, would label them in these terms to themselves and ultimately to others. External stigma is experienced by clients, as the perceived judgment that they encounter when seeking care. Fearing exposure to such judgment, they recoil from taking health-promoting behaviors.

RECOMMENDATIONS

- Stigma-informed client care.
- Internal process assessment that addresses agency attitudes to HIV, transphobia, homophobia and racism.
- Training for community practitioners to assure non-stigmatizing care.

EDUCATION

Like stigma, "education" emerged in every group and interview and was seen as an important intervention to counter stigma. The respondents defined education as disseminating accurate, thorough, and culturally relevant HIV-related information about prevention and treatment. Within the general populace, respondents noted that residents were grossly misinformed about basic details of HIV as a disease, woefully underestimated their personal risk, and were uninformed or misinformed about effective prevention measures. They concurred that the starting point in overcoming this was universal, standardized school-based sex education throughout the state. Beyond that, the respondents expressed concerns about how community members acquired information.

Most people with access to primary care would approach their physicians for information, however, as respondents indicated, these practitioners may not be equipped to provide the best data. Clinicians may underestimate risk in their patients or be insufficiently apprised of the protocols associated with PrEP and ART. Every one of the challenges facing PWH or those at risk is exacerbated in rural areas.

RECOMMENDATIONS

- Provide bio-psychosocial and intersectional components of health and health disparities.
- Enact best practices and provide gender-affirming care.
- Normalize and de-stigmatize prevention and treatment.
- Conduct an accurate, normalizing risk assessment.

LACK OF RESOURCES

As with the themes already presented, the lack of resources pervades every aspect of the HIV prevention and treatment milieu. The community-at-large, agencies and individuals are all confronted by financial limitations and other resources that can grievously affect the efforts to eliminate HIV. These situations create disparities in health outcomes intersectional in etiology as they have rarely been more obvious. States that expanded Medicaid under the Affordable Care Act improved access, while those who did not saw needs increasing. Alabama falls in the latter category.

Respondents spoke of vast swaths of the state with few HIV-related service providers. For example, they indicated that adolescents need to travel as much as 35 miles for services in some parts of the state. PrEP clinics are few in the state, and as discussed in the sections above, some clinics face threats of closure because of a lack of community financial or cultural support. At the individual level, many clients struggle with a significant lack of financial resources.

The constellation above forces people to prioritize among difficult choices, and when that happens, healthcare is usually de-emphasized in favor of feeding a family and paying rent. Providers repeatedly noted the financial burden to clients as a barrier to treatment and prevention. Lack of transportation was also cited as a barrier by many participants, especially those who live in rural areas. They expressed frustration that their clients who might benefit from PrEP or ART often go without because of cost, even though they may be eligible for discounted medication programs but are unaware of them.

RECOMMENDATIONS

- Increased allocation at the state and local levels to re-establish a stronger public health infrastructure.
- Increased collaboration among agencies to improve efficiencies and coordinate services.
- Increased access to clients to programs that provide financial literacy training, employment services, and program eligibility assessment.

CULTURAL CONSIDERATIONS

As with stigma, discussions of the need for culturally-appropriate service provision were a recurring theme among the groups' respondents, interviews and surveys. The lack of such services was among the most relevant and impactful barrier. African-American and other Black respondents echoed this observation and stressed that in HIV prevention and care, persistent race-based health disparities are most apparent. They cited numerous examples of research reporting the consistent pattern of poorer health outcomes found among African Americans. The disparities and lack of culturally-sensitive care are multiplied when the African-American client is LGBTQ+ and care can be complicated and compromised by homophobia and transphobia.

RECOMMENDATIONS

- Review and revise agency or clinic procedures and practices to assure that they are free of conditions that would compromise care based on racial bias or discrimination.
- Provide ongoing screening of clients to help them identify and address the bio-psychosocial and intersectional components of health and health disparities.
- Provide information and referral to agencies and services that can assist clients, when necessary.

A more detailed discussion of the issues faced by Spanish-speaking respondents and people with transgender experience is found in the *Special Topics* sections of this report. **The next sections present the findings related to the four EHE categories that are intended to inform the strategies to end the HIV epidemic: prevention, diagnosis, treatment and response.**

Despite extraordinary advances over the course of the HIV epidemic in understanding the bio-psychosocial factors associated with HIV risk, cases continue to rise. The needs assessment queried respondents on the following topics related to prevention:

1. General strategies that support HIV prevention
2. Barriers to prevention
3. Risk assessment
4. PrEP
5. SSP

As reflected in the discussion in the previous section, providers offered that prevention efforts for those at risk for HIV will be enhanced by implementing whatever strategies can be harnessed to:

- Reduce stigmatizing.
- Improve access to accurate, culturally-appropriate, timely information about sexual health information and HIV.
- Increase the resource base for public health, agencies and individuals.
- Culturally-appropriate care.

Within these admittedly global suggestions, the respondents provided specifics as discussed below. These themes will be repeated throughout the document.

Among the most frequently recurring suggestions were that HIV testing needed to be more widely available in more venues in every community. The community needs more information about HIV in general and prevention methods. To facilitate these suggestions, respondents stressed that testing needed to be normalized by inclusion in more contact points between the public and healthcare providers. Advance testing required more health-related marketing. Another strategy proposed by a healthcare provider was the possibility of more frequent contacts between persons-at-risk and their providers and access to services through other providers, such as Women, Infants and Children Nutrition Program, social services, etc.

Another key technique for prevention is effective and accurate risk assessment. Respondents were clear that risk assessment must be performed by individuals as well as by their healthcare providers. To do so, both groups need to

be armed with accurate information. In the discussion of *Recurring Themes* above, a physician noted his concern that clinicians or other service providers might fail to recognize their clients' risk factors and encouraged his colleagues to be more open to initiating risk discussions with patients. That tendency toward underestimating a panoply of factors can fuel risk. These factors include stereotyping, discomfort on the part of clinician or client, and lack of information or misinformation.

The development of PrEP was revolutionary in the prevention of HIV. As shown above, the EHE program focuses on more widespread use of PrEP. Participants were very supportive of PrEP but acknowledged that, despite its effectiveness as an HIV prevention, its use in Alabama is far less than what the need would predicate. The consistently expressed opinion of the participants is that PrEP eligibility criteria should be expanded. In addition, they advocated for more availability of both screening and prescribing. They were particularly interested in supporting community healthcare providers incorporating HIV risk assessment, PrEP eligibility screening and prescribing into their scope of practice.

Participants determined that those most at-risk are not sufficiently aware of PrEP. Such targeted information would greatly enhance risk assessment and screening by both individuals and their healthcare clinicians. Further, well-informed clients are often the first line of encouragement for PrEP use screening in their partners. Even when the information is available, there are too few options for receiving PrEP and concomitant support to those at-risk. Once again, there are egregious disparities by region and among those with limited resources. To address these situations, ADPH collaborates with communities and has created PrEP information interventions, but they are limited.

Respondents pointed out with optimism that messages promoting PrEP are more prevalent on mass media and social media. However, they want to encourage content producers to create images and messages that would enable a broader group of people to recognize that they may be appropriate PrEP clients. Further, they noted that there is not currently an effective referral network, nor is there an adequate number of PrEP providers.

Opinions about the SSP varied greatly among respondents. Several were unaware of its existence; however, they acknowledged the potential benefits when they learned of the program's details. There was general agreement that while not impossible to implement in Alabama, services could not currently be provided legally.

Misinformation about SSP and the complex factors associated with substance use were cited as significant barriers to adoption of the program. Despite the belief that SSP would be difficult to implement in Alabama, participants recommended several options to advance the program. Not surprisingly, the theme of "stigma reduction" was repeated in this context. This time, the details were expanded to include a plea for a better understanding of substance use.

Respondents who supported SSP did so adamantly. They suggested better alliances with agencies providing substance use disorder treatment and community information programs to improve acceptance. They stressed the importance of coordinated efforts for advocacy and political action. Finally, respondents pointed out that an essential benefit of SSP is harm reduction, not just for HIV, but for substance use disorder.

Since the appearance of COVID-19, control has been associated with repeated pleas for testing. For the HIV prevention and treatment community, such requests are quite familiar. While many options for HIV testing exist, participants reported that the community-at-large is often unsure about where they can be tested, when it is appropriate, and if they had been tested. Participants said that some clients believe inaccurately that HIV testing is part of their routine primary or gynecological care, for example. They reported that the client often requests an HIV test and that those requests are sometimes met with clinician skepticism, as discussed in the *Risk Assessment* section.

The respondents nearly universally and enthusiastically endorsed opt-out testing as a strategy for improving knowledge of HIV status. They frequently cited the usefulness of opt-out for normalizing, thus somewhat de-stigmatizing and reducing fear of an HIV diagnosis and improving testing rates. Despite the enthusiasm, the opt-out testing is far from standard procedure in Alabama. The organizational aspects of a clinic determine how clinicians communicate with clients. If it is not routine in the provision of care, some clinicians may experience discomfort in broaching the topic of sexual health.

From the perspective of the client, barriers to opt-out testing are essentially those discussed throughout this document. While opt-out testing may help normalize it and with proper information may improve its acceptance, financial considerations may interfere with the program's success. When discussing the availability of testing, participants agreed that access to testing is determined by location, with many rural areas being underserved. In addition to the barriers already presented here, they listed others to accessibility that most affect rural parts of the state, including number of sites, location of sites, transportation and actual or perceived costs.

Respondents offered that, depending on region, several different venues for testing were available, including health departments, ASOs, clinics, hospitals, campus health centers, drop-in centers, community medical practices, and CBOs. Despite this, they conceded that need exceeds access. Along with the need for an increased number and variety of testing sites, respondents emphasized the importance of outreach to inform potential clients of testing availability and facilitate its accessibility.

To determine how HIV screening might be more acceptable to the community, survey participants were asked what motivated them to seek out testing. In addition to the in-depth discussion of testing within this document, these responses can provide further information about how to best tailor health messaging to those at-risk.

Having unprotected sex with a person whose status was unknown was the most commonly cited motivation for survey respondents' testing. Testing at a hospital ER was the most frequent testing site for those who responded to the Spanish survey. While that might be an interesting finding, it is important to be cautious in extrapolating those findings beyond this analysis due to the small sample size.

Except for prevention, one of the most critical details the HIV-related messaging must promote is the importance and efficacy of ART and related HIV medical and ancillary care. ART equals hope for a relatively healthy life and the possibility of greatly reduced transmission of the virus to another person. But, like PrEP, universal access and use of ART are goals yet to be realized. The HRSA outcomes require an emphasis on rapid initiation of care and viral suppression by continuing care.

Survey respondents were asked about their transition to HIV care following their diagnosis. Half of the respondents in both groups indicated that they were given information (50 percent, N=33 English; 52.2 percent N=12 Spanish). Nearly three-quarters of the Spanish-speaking respondents (69.6 percent, N=16) were given an appointment to care at diagnosis, as were 43.9% (N=29) of the English speakers. For 20 percent (N=19) of the entire group, both information and an appointment were provided. Just over 10 percent of both groups were accompanied to their first appointment by a clinical staff member or peer.

The financial barriers discussed in each section of this document are relevant in considering both starting and continuing treatment. For English speakers, the rate of un-insurance plummeted from 39.4 percent at diagnosis to 4.4 percent at the time of the survey. That change seems to be related to more use of Medicaid and Medicare.

Psychosocial factors, beyond what has been presented about stigma and misinformation can be most acute at diagnosis. Fear of what it means to have contracted a potentially serious condition was mentioned as a barrier to starting and maintaining treatment by many focus groups and survey respondents. Clients, they reported, share

concerns about illness, shame, loss, loneliness and repeatedly and very poignantly, how an HIV diagnosis will affect their current relationships or ones they have yet to build.

To meet the goal of assuring that all PWH in Alabama receive the needed medical care, it is essential that services in rural areas be expanded. The factors presented already persist when considering access to treatment. Focus group and interview respondents suggested as they discussed PrEP, that one way to do that would be to deploy community primary care clinics as treatment sites.

But even current ASO and other HIV providers face challenges in offering their clients the range of services they consider the standard of care. Clinic logistics, availability of reimbursement and funding streams, and adequate staffing are among the challenges. Despite these and other challenges, providers have managed to create systems to remove barriers to care that their clients might face. The survey respondents rated the ease with which they could avail themselves of medical treatment and ancillary services.

Respondents in focus groups and interviews noted that while Alabama did not have an adequate number of treatment sites for ART, they were very encouraged by the patient outcomes for those they could reach. The barriers to ART are the same ones previously encountered, as are most of the facilitating factors. The providers who offered specifics indicated that the out-of-care rates in their practices varied between 5-10 percent annually, though about 3-5 percent will re-engage, a process one clinician referred to as the "churn phenomenon."

Respondents acknowledged that their agencies deploy a range of options to re-engage clients. As they learned from creating strategies for initiating client care, personalized and consistent contact with clients is essential. The information gathered from these contacts assists the clients and builds the data needed to determine best practices.

The information collected also reveals the challenges that clients face. Their needs are assessed, and they are encouraged with inventive means that help meet those needs. It was compelling how often and how intensely respondents stressed the importance of staff reaching out to clients individually and customizing the type and frequency of contact. From that, they can create a re-entry plan that most often entailed interventions beyond those usually within the scope of medical care. Many of the agencies that respondents represented enact systems for quickly tracking clients who are "no-shows" and try to assess and address reasons. Flexibility and timeliness were key. The importance of statewide and ADPH facilitated tracking was also discussed as critical to improving the efficiency and efficacy methods for keeping clients engaged. Supporting the interviews' findings, survey respondents reported which services were helpful for them to stay in care. For both groups, the interaction with providers (medical care) was the most important factor in maintaining care. Access to medications and the need to meet with clinicians to continue prescriptions may also contribute to maintaining care.

In the context of EHE, *Response* refers to the development and implementation of public policies that will, over time, facilitate the elimination of HIV infections. For this iteration of EHE, the emphasis for public policy is improving surveillance and response to HIV clusters.

ADPH has been diligent in assuring that HIV prevention and treatment providers and their clients were integrally involved in every phase of the planning process that will generate a strategic plan to address the EHE goals. Further, particular attention has been paid to assure that the participants represented as inclusive a group as possible.

Consistently, respondents reported that the overhauling of the data systems associated with testing results, clusters and outbreaks was essential. They focused on the need for better statewide coordination of data systems that disseminated various data points. The lack of timeliness of data was also a concern for respondents. They tied that concern to the need for more local capacity for data access and analysis that could then be reported to a more centralized data system.

SPECIAL TOPICS

Over the course of conducting the needs assessment, several topics emerged that were deemed worthy of additional consideration. As was seen in the "Themes" section, these topics infused several sections but warranted review beyond those targeted discussions. **These Special Topics include molecular HIV surveillance, unique challenges faced by Latinx people and unique challenges faced by people with transgender experience.**

CONSIDERATION OF MOLECULAR HIV SURVEILLANCE

During the discussion of "Response" at one of the EPC meetings, members were notably concerned about the proliferation of molecular surveillance. The responses ranged from expressions of vague discomfort to strident objections. To assure that this needs assessment might be a comprehensive reflection of community issues as possible, a focus group was scheduled to elicit participant thoughts on molecular surveillance. Generally, most service providers were at least moderately supportive of implementation of molecular HIV surveillance. They were clear about the potential benefits of the method, specifying its use in effective and rapid identification of clusters and capturing possible drug resistance in strains of HIV.

Underpinning all concerns was the fact that HIV status can lead to criminal prosecution in Alabama. With that information, objections centered around a stated mistrust of how data might be used. Respondents feared violations of privacy and worried that there had been inadequate transparency of how data might be used. The concerns were reported to be a concern for transgender persons, also. The mistrust was based on what is perceived as the history of data collection about PWHs and a lack of understanding within that community how data collection benefits them. The key to acceptance of molecular HIV surveillance among clients is a combination of accurate information about the value of molecular HIV surveillance from trusted sources and community involvement in the development and implementation of policies related to molecular surveillance.

CHALLENGES FACED BY LATINX PEOPLE

As would be expected, anti-immigrant public policies and political rhetoric can be, at the very least, inhibiting to Spanish-speaking individuals seeking care. The report repeatedly mentions the need for information and cites misinformation challenges as major hurdles in combatting HIV. Nowhere is that truer than for those with limited English language skills. Language barriers can exist in every facet of HIV education, prevention, and treatment. Lack of information resources can exacerbate cultural-based fears, stereotyping, and stigma. These can result in consequences that are medical and psychosocial.

Any of the barriers that might be present, whether language differences, misinformation, cultural misunderstanding, or resource limitation, can impact specifics of care and prevention.
Personal risk assessment is enhanced by culturally-directed information, and participants offered several strategies for improving access.

Respondents were also queried about how the members of their community learn about HIV to best determine their risk and about the actions necessary to prevent HIV. They indicated that there is quite a bit of reluctance to find out about HIV. To counter this, they requested that healthcare providers offer general HIV education and PrEP specifically more often while acknowledging the challenge in that. They stressed that Latinx persons who present for care need be met by someone to whom they can relate in language and hopefully in culture. Peer mentors appear to be key.

When asked about PrEP, respondents reiterated what others have said—that in addition to normalizing and information, partner communication is an essential feature for acceptance. The respondents characterized partner discussions about HIV status and PrEP as important for reasons that they framed as relational and responsible.

SUMMARY OF NEEDS FOR LATINX CLIENTS

- Culturally-competent care
- Culturally-appropriate information
- Elimination of barriers caused by immigration status
- Interpretation and translation services
- Latinx peer mentors
- Latinx healthcare and mental healthcare providers

UNIQUE CHALLENGES FACED BY PEOPLE WITH TRANSGENDER EXPERIENCE

Despite assiduous outreach efforts by service providers and advocates to transgender identified people, the team could not sufficiently recruit potential respondents to complete the survey. With the assistance of EPC, a group of transgender women agreed to participate in a focus group to discuss their experiences in securing healthcare in general and HIV prevention and treatment services. The six trans-identified women, including the facilitator, who met were not only very forthcoming in their individual responses but also validated each other's narratives as they were expressed.

People with transgender experience tend to encounter the barriers to care that have been discussed earlier. They can be beset with financial obstacles, be underinsured or uninsured, for example. Several other themes were posited and affirmed by the participants when considering their healthcare: gender-affirming care, stigma, client priorities and, health promotion practices.

The minimum standard of care for trans-identified persons should be gender-affirming care, the participants asserted. They requested that this start from the first moments of contact and includes assuring use only of a chosen name, asking about appropriate pronouns, and making no assumptions about physiological features. It also presupposes that providers be sufficiently comfortable treating people with transgender experience. The women of trans-experience noted that it often falls on them to ask for that care and educate providers on how to deliver it.

Participants opened the session by noting that people with transgender experience are among the most underrepresented communities in every phase of society. Representation has a very concise meaning in the context of healthcare. Gender-affirming care further assumes that clients are three-dimensional beings whose medical needs include gender care but extends beyond that. The clients who need hormone treatment reported frustration at how few physicians were available to them.

Participants were vehement in their assertions that more than the other communities discussed previously in this report, trans-identified persons face stigma that is pervasive and intense. They noted that they confront stigma in every aspect of their lives but were especially disheartened that they often define their healthcare in that context. That they were also transwomen of color enhanced the likelihood of being stigmatized.

The respondents were most adamant in relating how often they felt stigmatized because of the stereotyping that is sometimes associated with transgender identities. They felt that they were characterized in aggregate and not as individuals with specific features and specific needs. They expressed great offense that they felt that they were at times sexualized and not consistently seen as women with a range of competencies, experiences, and needs. They related numerous experiences where HIV client education and prevention messaging seemed geared more to MSM than them. They also cautioned that providers should not make assumptions about their transition status without confirmation of it.

The discussion about PrEP revealed participant attitudes that ranged from supportive through ambivalent to opposed. Those who were supportive of PrEP promotion to women with transgender experience acknowledged PrEP's effectiveness but also stressed that marketing to transwomen was inadequate and offered recommendations. Those

who were ambivalent about or opposed to PrEP despite noting the benefits prioritized those far below their concerns about what they believed were risks of potential interaction between PrEP and hormone treatment. The CDC indicates that more research is needed to address that potential. Participants who were skeptical about PrEP believed that they are not being given adequate or accurate information about PrEP, as well as ART and hormone therapy interactions to make reasoned decisions. They were unsure about the direction of the potential drug interactions, and in their reported experiences, the topic was not addressed when they were encouraged to initiate or maintain PrEP.

As research continues to explore the potential for pharmacological interactions, the psychological impact of care should also be considered. It is apparent that for trans-identified women to truly make the most informed decisions, their priorities must frame all conversations about prevention, treatment, and care, particularly when PrEP or ART may be indicated.

Participants were asked if some practices or policies allowed trans-identified women to maintain HIV treatment. Their responses reflected facilitating experiences and those that resulted in frustration. The respondents noted that some of the difficulties of staying in care for HIV are related to finances. They reiterated that though their gender-related care is a core priority, they want to be treated more comprehensively. They were particularly clear about the importance of believing their clinicians are hearing them.

SUMMARY OF NEEDS FOR CLIENTS WITH TRANSGENDER EXPERIENCE

- Gender affirming care
- Prevention and treatment information that is relevant to their context
- Elimination of barriers caused by transphobia or lack of experience
- Care that combines gender care with HIV prevention and treatment
- Peer mentors and staff who are transgender-identified
- Healthcare and mental healthcare providers who are trans-identified or competent in treating clients with transgender experience.

IMPACT OF UNSTABLE HOUSING ON PWH AND PEOPLE AT-RISK FOR HIV

It is hardly a revelation to suggest that unstable housing and homelessness create intersectional difficulties that put those experiencing them at serious risk for HIV exposure and particularly challenged if attempting to secure the care that HIV necessitates. Further, the risks faced are bi-directional—PWH are at higher risk of housing insecurity and homelessness and those beset by housing issues are at higher risk of contracting HIV.

Research has shown that poverty is the most highly associated factor leading a person to be housing insecure or homeless. Too often corollary factors, such as stigma, mental illness, physical disability, history of incarceration, systemic racism, and other discriminatory ideologies are embedded with their own widespread stigmatizing attributions. Obviously, compromises to the ability to meet basic needs can increase the incidence of participation in risky behaviors, from survival sex work or drug-related transactions.

Insecure housing can exacerbate pre-existing mental illness or new-onset mental illness brought about by the situation. Debilitating levels of depression or anxiety, for example, can be not only precursors to housing insecurity and homelessness, but also a result of these destabilizing and fear-laden situations. Maintaining HIV prevention practices, even if they are known, under these conditions, can seem impossible. Few events could be more disruptive under these conditions than a diagnosis of HIV.

Clients in homeless service organizations and shelters could be better served if they had access to HIV-related information, testing, prevention, and treatment care. Though some HIV-service agencies offer such care in those organizations, those who do not noted the advantage that could be gained from being able to do so.

SUMMARY OF NEEDS FOR CLIENTS WITH UNSTABLE HOUSING/HOMELESSNESS

- Access to Rapid Rehousing, Housing First services
- Evidence-based programs to prevent homelessness
- HIV prevention and treatment information delivered with services to those experiencing homelessness
- Services that provide valid identification
- Mental health and substance use treatment services
- Incorporation of the assessment of basic needs with HIV risk assessment and service delivery
- Transportation to services for persons experiencing homelessness
- Education programs to reduce stigma and support HIV status disclosure

CONCLUSION

The next step in the planning process that began with this assessment of needs, will be the development of a strategic policy and services plan. The plan will be informed by this report and by continuing input from the community members, services, clients, and providers that the plan is intended to serve. With that input, the resultant plan will attempt to address and overcome the intersectional barriers Alabamians may have confronted in HIV prevention and treatment. The goal is a set of strategies that effectively End the HIV Epidemic in Alabama.