ENDING *the* HIV EPIDEMIC
ALABAMA

ALABAMA PUBLIC HEALTH

Ending the HIV Epidemic (EHE)

Alabama Department of Public Health (ADPH)
Office of HIV Prevention and Care (OHPC)
Jurisdictional Plan (Condensed Version)

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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. For more information about the Plan or community engagement activities, please contact the Acting Director EHE Program Branch or one of the three End HIV Alabama (EHA) Co-Chairs below:

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INTRODUCTION

INTRODUCTION

HIV in Alabama

The HIV/AIDS epidemic in Alabama is of moderate magnitude compared to other states. Approximately 1.1 million people in the United States are living with HIV. The CDC estimates that 14 percent of these people are unaware of their infection. According to the CDC, approximately 38,000 new infections occur in the United States each year. Between 1982 and 2017, a total of 21,302 cases of HIV infection were reported to ADPH. Alabama's HIV epidemic includes more than 15,000 PWH, with between 650 to 700 newly diagnosed cases reported each year. One-quarter of newly diagnosed cases have an AIDS-defining condition at the time of diagnosis, indicating late diagnosis in a long-standing infection. In addition to the reported HIV burden, prevalence estimates indicate 1 in 6.5 PWH in Alabama are unaware of their infection, bringing the estimated number of cases to over 17,800. Alabama's HIV Continuum of Care shows 57 percent of diagnosed PWH were retained in care during 2018, meaning as many as 43 percent of PWH did not receive continuous HIV medical care.

Alabama is primarily rural: 55 out of 67 counties are located outside of the state's major and minor urban populations, and 40 counties are considered to be extremely rural. Only seven counties are in major urban centers, and another five are located in minor urban centers. While most PWH live in more populated counties, rural counties that tend to be medical care deserts without adequate access to standard medical care or specialized HIV care, report the highest prevalence of HIV. Data trends reveal HIV infects and affects persons of all genders, ages, races, ethnicities, and socioeconomic groups in Alabama. Certain populations, however, are more affected and experience the highest rates of associated health disparities. These include:

- Gay and bisexual men (GBM) and other men who have sex with men (MSM), especially black and Latinx GBM, within age clusters and specific characteristics and needs (youth and older GBM)
- Persons identifying as transgender
- Cisgender women, especially African American women
- People who inject drugs (PWID)

The emergence of COVID-19 created another health burden for PWH. State-wide safety measures and coronavirus morbidity have complicated health care access and the delivery of HIV prevention and care services. Some organizations that provide crucial services are not yet functioning at their pre-syndemic capacities. Housing instability, loss of income, food insecurity, isolation, and severe illness are some additional challenges PWH have faced because of the COVID-19 pandemic.

Ending the HIV Epidemic Jurisdictional Plan Approach

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.



COMMUNITY ENGAGEMENT

"You want people to know that they will have people who are going to be with them... You want to have someone who can walk with you and learn as you learn about yourself as you begin to make a new plan [for treatment]. That plan could include transportation or housing assistance. [We] make sure that the basic needs are being met for folks before we can ask them to make a huge commitment like changing their lifestyles. They are already in an uncomfortable position."

COMMUNITY ENGAGEMENT

Purpose

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.





Background

Upon learning of the EHE Initiative, Dr. Scott Harris, State Health Officer, formed an EHE Leadership Team comprised of OHPC staff and leadership from ASOs in Montgomery and Birmingham. Initially ASOs throughout the state were asked to designate two delegates to help staff the committee. The team's planning conversation was to ensure that the community had a voice and that strategies and activities of the plan were relevant to their communities.

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.
- Establish an EPC, also known as EHA.

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 al[1]). 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.

1. *Principles of Community Engagement: Definitions and Organizing Concepts from the Literature.* Donna Jo McCloskey, RN, Ph.D., (Chair), Mary Anne McDonald, DrPH, MA, Jennifer Cook, MPH, Suzanne Heurtin-Roberts, Ph.D., MSW, Stephen Updegrove, MD, MPH, Dana Sampson, MS, MBA, Sheila Gutter, Ph.D., Milton (Mickey) Eder, PhD

"Sometimes you cannot even talk to people about HIV because they think it is something awful. Our community is not educated on this matter. Sometimes people don't even want to mention it. The priority needs to be the education about the risk of getting HIV, life after diagnosis and everything else.
This condition is not a death sentence, people need to know that."

FY2020 Community Engagement Activities

March

- Data collection plan for Community Needs Assessment developed.
- Recruitment for priority populations.
- Community and client surveys distributed in English.

April

- EHA meeting via Zoom.
- Community and client surveys were distributed in Spanish.
- Focus groups were conducted with Linkage Specialists (peer mentors).
- Focus group conducted with Positive Living Council.

May

- EHA meeting via Zoom.
- Eight provider telephone interviews were completed.
- Worked with an English to Spanish translator/interpreter to recruit Hispanic/Latinx members, translate documents, send email, phone members, and interpret as necessary for monthly meetings.
- Focus group conducted with ASO staff throughout the state.
- Focus group conducted with The Knights and Orchids (TKO) Society, a lesbian, gay, bisexual, transgender, queer (LGBTQ) advocacy group.
- Focus group conducted with Hispanic/Latinx community members.

June

- EHA meeting via Zoom.
- Focus group conducted on molecular surveillance issues.
- Focus group conducted with housing/homeless prevention professionals.

July

- EHA meeting via Zoom.
- Completed quantitative data collection.

August

- EHA meeting via Zoom.
- Completed draft situational analysis from data collected through needs assessment and EHA meetings.
- Formed a Branding and Marketing Sub-Committee.
- Started a private Facebook page for the Committee to share information and post updates.

September

- EHA meeting via Zoom.
- Held a Situational Analysis review meeting for EHA via Zoom.
- Adopted a Committee logo.

October

- EHA via Zoom.
- Established two additional subcommittees: Membership and Advocacy/Legislative.
- Committee voted via electronic survey on date and time changes for meetings to include more community members throughout the state.
- EHE Jurisdictional Plan rough draft presented to Committee.





"The HIV positive partner will disclose and educate their partner. Partner communication is very important. When you have a partner you need to talk about this [and tell them that we have this medication [PrEP] as an option and you can have a fulfilling life even with this condition."

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.



EHE Strategy	Community Input Source
Strategy 1A. Expand or implement routine opt-out HIV screening in healthcare and other institutional settings in high prevalence communities.	Interviews Focus groups July's EHA meeting
Strategy 1B. Develop locally-tailored HIV testing programs to reach persons in non-healthcare settings.	Interviews Focus groups July's EHA special topics focus groups included individuals identifying as transgender and Latinx, and those experiencing homelessness
Strategy 1C. Increase at least yearly re-screening of persons at elevated risk for HIV infection per CDC testing guidelines, in healthcare and non-healthcare settings.	Interviews Focus Groups

"When they [providers] find out that [I am a transgender woman], I just embrace the moment. I am becoming comfortable with myself and so I make them more comfortable so that they can learn to understand. I want them to see us as just another human being, just like them."



EHE Strategy	Community Input Source
Strategy 2A. Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV	Interviews Focus groups Client surveys August's EHA special topics focus groups included persons identifying as transgender and Latinx, and those that are experiencing homelessness
Strategy 2B. Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Program (RWHAP).	



EHE Strategy	Community Input Source
Strategy 3A. Accelerate efforts to increase Pre-exposure prophylaxis (PrEP) use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP.	Interviews Focus groups Client surveys Community surveys August's EHA special topics focus groups included persons identifying as transgender and Latinx, and those that are experiencing homelessness
Strategy 3B. Increase availability, use, and access to and quality of comprehensive syringe services programs (SSPs).	

RESPONSE

EHE Strategy	Community Input Source
Strategy 4A. Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response.	Interviews Focus groups May's EHA special topics focus group was on molecular surveillance
Strategy 4B. Investigate and intervene in networks with active transmission.	
Strategy 4C. Identify and address gaps in programs and services revealed by cluster detection and response.	

Priority Population	Identified Needs	Community Input Sources
Persons who identify as transgender	HIV testing STD testing HCV testing Partner services Health education Prevention services	Interviews Focus groups Client survey Community survey May's EHA special topics focus groups included persons identifying as transgender and Latinx, and those that are experiencing homelessness
Cisgender women of color		
PWID		
Gay African American men		

EHA Monthly Meetings

The EHA currently meets monthly on a weekday morning. Recently, the membership voted to alternate meetings each month between a weekday morning and a weekend or evening to accommodate as many schedules as possible. Meeting dates and times are scheduled three months in advance and are published on the agendas that are emailed to the membership and posted on the EHA Facebook page.

Due to the COVID-19 pandemic, the membership meets virtually via Zoom. This has proven to be a great way to engage members who would not have the time or the means to travel to a meeting even under

"Education helps us to understand that we are responsible for ourselves. We can educate ourselves and then go from there to educate others. You go to the health fair and invite others to get tested."

normal circumstances. As of October 31, 2020, the Committee has 77 members representing 12 counties and 25 CBOs. Meeting agendas can be found at https://www.alabamapublichealth.gov/hiv/ehe.html.

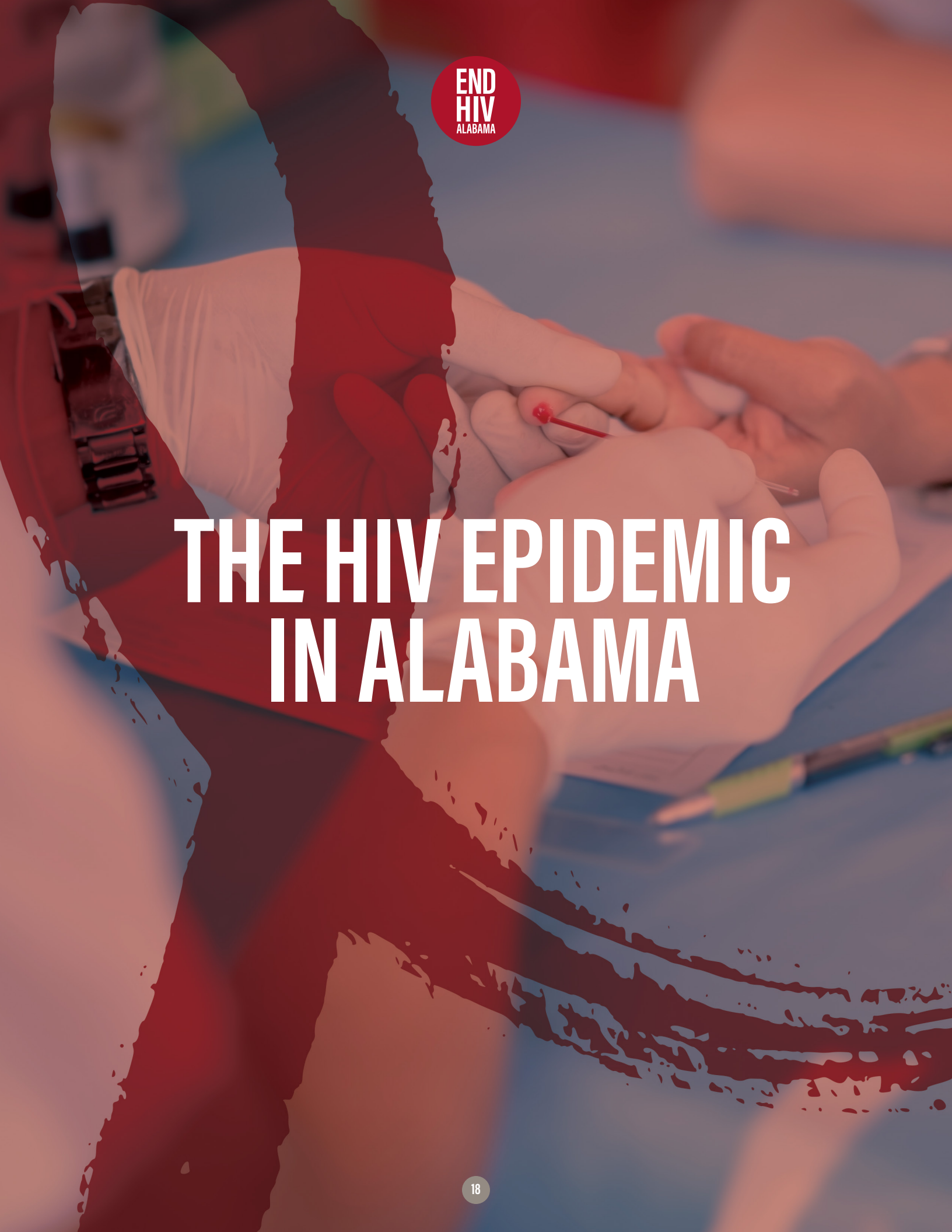
Stakeholders and Key Informants Who Were Not Involved but Are Needed

During the planning process, additional agencies, special interest groups, and individuals were identified by participants for inclusion in planning efforts. A survey was distributed to the EHA membership to capture a demographic snapshot. Although there is good diversity within the membership, the survey results revealed that future recruitment efforts need to be targeted to individuals with comparably lower income, people with transgender experience, legislators, youth, people of Hispanic ethnicity, and community members who do not represent an agency. The logos that appear in this document were recently adopted to market "Ending the HIV Epidemic Alabama" to a wider audience.

EHE Planning Membership

Miguel Angel Anaya, AIDS Alabama, Jefferson County
Carmarion D. Anderson-Harvey, HRC, Jefferson County
Michael Bailey, Medical Advocacy Outreach (MAO), Montgomery County
Quentin Bell, TKO Society, Dallas County
Leatha Bennett, Alabama A&M University, Madison County
Erin Bortel, Thrive Alabama, Madison County
Cynthia Boykin, AIDS Alabama South, Mobile County
Elea Bradford, Etowah County
Brittney Brooks, Alabama Partners for Health, Inc., Madison County
Jawandalyn Brooks, Alabama Coalition Against Domestic Violence, Montgomery County
Shakita Brooks-Jones, Resource and Advocacy Center, Elmore County
Ashley Brown, Auburn University, Lee County
Josh Bruce, Birmingham AIDS Outreach (BAO), Jefferson County
Chandi Butler, Capital City Gastroenterology, Montgomery County
Marcus Butler, Rehab Select, Montgomery County
Adrinda Carter, OHPC, ADPH, Montgomery County
Tony Christon-Walker, AIDS Alabama, Jefferson County
Larry Cowan, Selma AIR, Dallas County
Danita Crear, OHPC, ADPH, Montgomery County
Steve Dellinger, ADPH, Jefferson County
Laurie Dill, MAO, Montgomery County
Donna Duke, Tuscaloosa Diversion Program, Tuscaloosa County
James Duke, ADPH, Madison County
Jerome Edwards, Five Horizons, Tuscaloosa County

Kimberly Edwards, OHPC, ADPH, Montgomery County
LaTeisha Elliott, Alabama Partners for Health, Inc., Madison County
Morgan Farrington, GoodWorks: North Alabama Harm Reduction, Madison County
Anthony Gardner, Alabama Regional Medical Services, Jefferson County
Richie Hailey, ADPH, Madison County
Scott Harris, State Health Officer, ADPH, Montgomery County
Tony Hawkes, Thrive Alabama, Madison County
Dominique Hector, AIDS Alabama, Jefferson County
Jholett Hernandez, AIDS Alabama, Jefferson County
Pablo Hernandez, AIDS Alabama, Jefferson County
David Hicks, Jefferson County Health Department (JCHD), Jefferson County
Kathie Hiers, AIDS Alabama, Jefferson County
Chelsey Holland, OHPC, ADPH, Montgomery County
Julie Hope, AIDS Alabama, Calhoun County
DaRhonda Jackson, Montgomery County
Karen Johnson, The University of Alabama (UA), Tuscaloosa County
Sharon Jordan, OHPC, ADPH, Montgomery County
Jonathan Joseph, OHPC, ADPH, Montgomery County
Randy Kelly, Montgomery County
Billy Kirkpatrick, Five Horizons, Tuscaloosa County
Sarah Laurio, Dumas Wesley Community Center, Mobile County
Ritalinda Lee, Claris Advocates
Kimberly Love, Alabama Coalition Against Rape, Montgomery County
Barbara Lowery, Five Horizons, Tuscaloosa County
Mary Elizabeth Marr, Thrive Alabama, Madison County
Vontrese McGhee, OHPC, ADPH, Montgomery County
Mary McIntyre, Chief Medical Officer, ADPH, Montgomery County
Anthony Merriweather, Communicable Disease, ADPH, Montgomery County
Oronde Mitchell, City of Montgomery, Montgomery County
Michael Mugavero, University of Alabama – Birmingham (UAB), Jefferson County
Michael Murphree, MAO, Montgomery County
Karen Musgrove, BAO, Jefferson County
Warren O'Meara-Dates, ADPH, Etowah County
Melissa Parker, Health Services Center, Calhoun County
Jitesh Parmar, Thrive Alabama, Madison County
Pamela Payne-Foster, UA Medical School, Tuscaloosa County
Charlotte Petonic, UA Project Health, Tuscaloosa County
Joel Reed, Alabama Department of Rehab Services, Morgan County
Lawanda Richardson, Selma AIR, Dallas County
Martha Robinson, ADPH, Montgomery County
Brittany Sanders, JCHD, Jefferson County
Ana Santos, Alabama Partners for Health, Inc., Madison County
Shirley Selvage, UAB 1917 Clinic, Jefferson County
Willie Smith, New Salem Christian Church, Montgomery County
Julia Sosa, Whatley Health Services, Tuscaloosa County
Derrick Steverson, Five Horizons, Tuscaloosa County
Ashley Tarrant, MAO, Montgomery County
Shey Thomas-Thorn, AIDS Alabama, Jefferson County
Kelly Turner, Health Services Center, Calhoun County
Angelia Walton, Teens Empowerment Awareness with Resolution, Inc., Russell County
Tracy Wayne, East Alabama Medical Center, Lee County
Brittney Washington-Ball, Whatley Health Services, Inc., Tuscaloosa County
Jora White, OHPC, ADPH, Montgomery County
Andrew Yarnell, First Methodist Church, Jefferson County



THE HIV EPIDEMIC IN ALABAMA

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

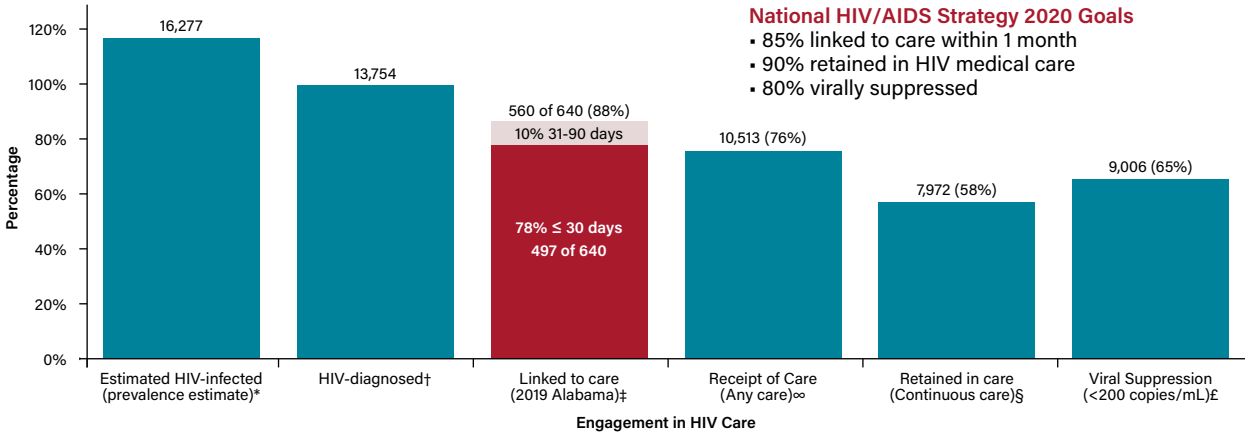
* (does not include “unknown”)

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

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:

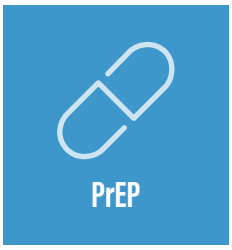
- Reduce stigmatizing.
- Improve access to accurate, culturally-appropriate, timely information about sexual health information and HIV.
- Increase the resource base for public health, agencies and individuals.
- Culturally-appropriate care.

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.



THE PLAN TO END HIV

Pillar One: Diagnose

Diagnosis is the first step in the HIV Care Continuum and designed to identify and link undiagnosed individuals to HIV care. In this pillar, the EHA Plan focuses on implementation of pilot programs involving opt-out screening, normalizing HIV and Hepatitis C Virus (HCV) testing in non-traditional settings and establishing a system to re-screen individuals at high risk for infection. ADPH seeks to partner with Baptist Medical Center, CHDs, CBOs, faith-based organizations, ASOs, and Federally Qualified Health Centers (FQHCs).

Goal: Diagnose all individuals with HIV as early as possible after infection.

Strategy 1A.

Expand or implement routine opt-out HIV screening in healthcare and other institutional settings in high prevalence communities.

Year 1

ADPH will implement a pilot program to institute opt-out screening at the ER at the Baptist Medical Center East in Montgomery County, due to the high prevalence rate.

This activity includes the following sub-activities:

- Identify a "champion" to lead the activities to routinize HIV screening at intake.
- Modify the electronic health records (EHRs) to routinize the offer of screening and screen all patients at least once for HIV regardless of risk.

ADPH will implement opt-out screening for HIV and the HCV in all county CHDs statewide.

This activity includes the following sub-activities:

- Update current ADPH regulations to include opt-out screening at all CHDs.

- Train key staff on regulations and procedures to ensure opt-out screening is routinely performed.
- Modify EHRs to routinize the offer of screening and screen all patients at least once for HIV regardless of risk.

Year 2-5

Continuation of Year 1 activities at Baptist Medical Center East and ADPH's local CHDs. If successful and in phases, expand the pilot to the two other hospitals' EDs within the Baptist Medical Center System, Baptist Medical Center South and Prattville Baptist Hospital, and its various urgent care facilities; and to the EDs at the other medical centers within the five highest burden counties.

Expand incremental compliance to opt-out HCV testing to all adults at-risk or willing to be tested in county clinics considered to be high-yield.

AIDS Alabama will implement routine HIV screenings in private practices and FQHCs to increase the number of patients who know their HIV statuses.

Strategy 1B.

Develop locally-tailored HIV testing programs to reach persons in non-healthcare settings.

Year 1

OHPC will normalize HIV and HCV testing in non-traditional settings by providing multiple options to receive HIV tests.

This activity includes the following sub-activities:

- Develop partnerships with tribal organizations, faith-based institutions, and homeless shelters to conduct annual testing; and to develop partnerships with rape crisis centers (RCCs) and domestic violence centers (DVCs) to conduct testing as a part of the sexual assault examination and during entry into shelters.
- Expand testing on college campuses beyond historically black colleges and universities and at pharmacies, jail and youth detention facilities, substance abuse treatment facilities, LGBTQ centers, night clubs and bars, and adult entertainment venues.

- Conduct health fairs and pop-up testing events whereby HIV and HCV testing are offered as a service bundled with screening for other conditions relevant to the local population in the five highest burden counties and 14 emerging rural counties identified.
- ASOs will partner with non-traditional entities such as city governments, housing authorities, RCCs, DVCs, traditional housing communities, barber shops, hair and nail salons, and outdoor sporting events to test participants in mobile testing units.
- Incorporate strategies to rapidly link persons to HIV medical care, support and prevention in all non-traditional settings.

Year 2-5

Continuation of Year 1 activities and to identify other statewide annual events to create educational and testing opportunities, i.e., The Magic City and Turkey Day Classics, jazz festivals, concerts, health fairs and pop-up testing events in lower income housing communities. Modifications will be made depending on the success of the activities. Additional TA will be provided to key staff and organizations providing testing services.

Strategy 1C.

Increase at least yearly re-screening of persons at elevated risk for HIV infection per CDC testing guidelines, in healthcare and non-healthcare settings.

Year 1

ADPH will establish a system to re-screen high risk clients identified.

This activity includes the following sub-activities:

- Utilize the National Electronic Disease Surveillance System to follow up with clients referred for PrEP medication.
- Develop a centralized database, such as Research Electronic Data Capture, with baseline HCV testing data of all participants.
- Create community inspired testing activities and events to encourage participation from priority populations.

Year 2-5

Continuation of Year 1 activities and identify other local community driven events to create opportunities for testing and re-engagement, i.e., mobile testing, ballroom competitions, skate parties, Pride events, homeless shelters, RCCs and DVCs community awareness events (Sexual Assault Awareness Month in April and Domestic Violence Awareness Month in October), and other outreach activities.

Verify frequency and longitudinal trends of re-testing, rates of HCV seroconversion (new infections) and monitoring the detection of clusters.

Expand expedited and rapid HIV and syphilis testing to non-CHDs facilities.

Coordinate rapid linkage to HIV medical care and prevention services for persons screened or newly diagnosed with HIV and syphilis through prompt provider and Disease Intervention Specialist (DIS) notification.

Pillar Two: Treatment

The next steps in the HIV Care Continuum are linkage to and receipt of HIV medical care. Engaging people who have been diagnosed with HIV in effective treatment to lower their viral load has not only a major health benefit, but a crucial HIV prevention benefit. Under this Pillar, the Plan seeks to improve rapid linkage and re-engagement to care by partnering with organizations in high-HIV burden districts.

Goal: Treat PWH rapidly and effectively to reach sustained viral suppression.

Strategy 2A.

Ensure rapid linkage to HIV care and ART initiation for all persons with newly diagnosed HIV.

Year 1

ADPH will partner with JCDH to implement rapid linkage to HIV medical care for persons newly diagnosed with HIV.

This activity includes the following sub-activities:

- Identify persons newly diagnosed with HIV and ensure rapid linkage to care and start ART within 7 days.
- Conduct a rapid needs assessment for all newly diagnosed persons with HIV and link to an ASO, as needed.

Additional activities for rapid linkage to care and ART are:

- Develop process in the Bureau of Clinical Laboratories (BCL) to allow for increase in HCV reflex testing volume and notification of test ordering entities.
- ASOs will create partnerships with primary care locations to implement rapid linkage programs that decrease delay to three days or less.

Year 2-5

Continuation of Year 1 activities at JCDH and if successful, repeat this process at other local CHDs in the five highest burden counties identified. Modifications will be made depending on the success of the activities. Additional TA will be provided to key staff promoting rapid linkage.

Increase testing volume for uninsured patients.
ASOs will partner with primary care and infectious disease practices, and Ryan White clinics to create Memoranda of Understanding to expedite linkage to ART.

Strategy 2B.

Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not recipients of RWHAP.

Year 1

ADPH will re-engage and link PWH who are not-in-care (NIC) to HIV medical and support services.

This activity includes the following sub-activities:

- Scale up the Data to Care (D2C) program using Enhanced HIV/AIDS Reporting System to identify clients NIC ≥ 12 months. HIV Re-engagement Program (HREP) staff will link PWH who are NIC back into HIV medical care and support services.
- Develop a data sharing agreement with the Alabama Medicaid Agency (Medicaid) to access claims to identify HIV clients NIC.
- Train CHD staff on telehealth programming to support and promote long-distance clinical health care.
- Assess the opportunity to link HIV positive cases to chronic HCV cases (HIV/HCV co-infection finding).

Year 2-5

Continuation of Year 1 activities and if successful, conduct bi-annual NIC match with data from Medicaid and evaluate the effectiveness of D2C to re-engage HIV mono-infected and HIV/HCV co-infected patients to care.

Pillar Three: Prevent

Although not a part of the HIV Care Continuum, prevention plays an integral role in ending the HIV epidemic. ADPH will increase the usage of PrEP among higher-risk populations through strategic partnerships, community education, and an enhanced referral system. The EHA will collaborate with local advocates for SSPs to educate the public and work to make such programs lawful in Alabama.

Goal: Prevent new HIV transmissions by using proven interventions, including PrEP, PEP, and SSPs.

Strategy 3A.

Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP.

Year 1

ADPH will increase the usage of PrEP medications among populations at highest risk of contracting HIV.

This activity includes the following sub-activities:

- Integrate *Ready, Set, PrEP* information into providers, and RCCs, and DVCs trainings.
- Develop partnership with the Alabama chapter of International Association of Forensic Nurses to implement an HIV module within the existing sexual assault nurse examiners (SANE) trainings that include the annual trainings, refresher courses, and trainings for new nurses.
- Educate and inform local communities through peer navigators, various outreach events, social media posts, and marketing campaigns representative of the target audience to raise awareness of PrEP medications and *Ready, Set, PrEP.*

- Revise the plan to identify and refer CHD clients that are high-risk negatives for PrEP services.
- Develop a plan to conduct STD, HIV, HCV, Hepatitis B Virus (HBV), and creatine testing through the Bureau of Clinical Diseases at designated ASOs and other healthcare facilities providing PrEP services.

Year 2-5

Continuation of Year 1 activities and partner with PrEP providers to educate the public and providers on the usage of PrEP, and partner with healthcare providers and facilities on becoming a PrEP provider modification will be made depending on the success of the activities.

Conduct trainings for SANE, especially those that work with standalone SANE facilities.

Strategy 3B.

Increase availability, use, and access to and quality of comprehensive SSPs

Year 1

ADPH will defer advocacy activities to the EHA which will:

- Organize a sub-committee of the EHA to collaborate with CBOs who advocate for and educate about SSPs.
- Sub-committee will engage with state legislators who are currently working to change the Alabama law that prohibits needle exchange programs.

Pillar Four: Respond

The last pillar, Respond, addresses the use of surveillance data to improve efficiency, identify gaps in services, and ultimately improve the quality of care. Most of these activities will be the responsibility of the HIV Cluster Committee (HCC) which will guide cluster response, and the HIV Outbreak Response Team (HORT) which will be deployed to provide program evaluation and conduct investigation during an outbreak.

Goal: Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Strategy 4A.

Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response.

Year 1

The HIV Surveillance Branch will establish an HCC to guide cluster response. The HCC will be comprised of ADPH staff, leaders from CBOs, and healthcare professionals.

This activity includes the following sub-activities:

- The HCC will meet quarterly to review identified cluster networks, evaluate current protocols, and address identified gaps in services.
- The Surveillance Branch will use Secure HIV-Trace to rapidly analyze, integrate, and share data from molecular surveillance.

Year 2-5

Continuation of Year 1 activities.

Strategy 4B.

Investigate and intervene in networks with active transmission.

Year 1

The HORT will be deployed during an outbreak.

This activity includes the following sub-activities:

- HORT activities will be expanded to include extensive medical record reviews to identify missed opportunities.
- The newly established HCC will provide additional oversight to the HORT which will include policy review and assist surveillance staff with addressing problematic evaluation outcomes.
- The HCC, in collaboration with the HORT, will evaluate networks and prioritize members for enhanced linkage services such as testing and future re-testing, PrEP, HIV medical care, and other support services focusing on partners of transmission cluster members who were not known to be HIV positive at the time of cluster identification.

Year 2-5

Continuation of Year 1 activities.

Strategy 4C.

Identify and address gaps in programs and services revealed by cluster detection and response.

Year 1

HIV Surveillance staff will review and analyze cluster data to identify specific gaps in HIV related programs and services.

This activity includes the following sub-activities:

- Identify the need for additional testing sites, education, and support services through ethnographic assessments.
- Evaluate, visualize, and publish cluster data to the HIV Surveillance Branch website.

Year 2-5

Continuation of Year 1 activities.



MEASURING PROGRESS

EVALUATION PLAN

Introduction

It has been nearly 40 years since HIV was first recognized. Despite extraordinary progress in detection, treatment, and prevention, the epidemic still progresses. As of today, there is no cure, an effective vaccine remains elusive, and the persistence of disparities in access to health resources leaves specific populations more vulnerable to infection.

In recognition of ongoing threats that the virus presents, the CDC has marshaled information about the best practices in HIV prevention and treatment for the EHE Initiative, which is focused on jurisdictions. The jurisdictions include 48 counties; San Juan, Puerto Rico; and Washington, DC.; whose rates of HIV infection continue to increase, and for whom prevention and treatment resources are inadequate to address those increases.

ADPH is a recipient of an EHE grant and is in the process of developing a strategic plan to meet the goals of the EHE Initiative. Specifically, EHE focuses on the following pillars: diagnose, treat, prevent, and respond[1] to end the epidemic.

Part of the requirements for the strategic plan is the inclusion of a comprehensive evaluation plan. CDC has provided grantees with an evaluation logic model that details a list of outcomes to monitor and report. The report is a draft of the evaluation plan that will be proposed to ADPH as part of their strategic plan.

Components

The final evaluation plan will be comprised of the following:

- Review of CDC requirements.
- Assessment of current status within the HIV prevention and treatment communities to collect required data.
- Recommendations for preparing for evaluation.
- Review of ADPH evaluation goals and current data collection processes.
- Discussion of needs assessment findings used to develop the strategic plan.
- Data collection, analysis, and reporting plans.
- Implementation schedule.

The current document focuses on:

- Review of CDC requirements.
- Assessment of current status.
- Recommendations for preparing for comprehensive evaluation.
- Limitations imposed by the COVID-19 pandemic.

Current Status: Preparing for Comprehensive Evaluation

DATA INFRASTRUCTURE

ADPH staff involved in HIV prevention and treatment are currently in the unenviable position of now attempting to manage an epidemic within a pandemic of COVID-19. Thus, the evaluation planning that might have been proposed a year ago must now be revised to accommodate the utterly altered reality caused by the pandemic.

As with every other government agency, health departments are unclear what resources will be allocated or reallocated to the pandemic mitigation and response, and how this might affect their current and future operations. This evaluation plan considers these issues, and, hopefully, there will be more clarity for health departments over the next few months.

Compliance with CDC's evaluation goals will necessitate a review of the current data process that ADPH engages with its grantees and partner agencies to generate such information as the epidemiology reports and comprehensive plan required by the Ryan White Care Act. Current systems may be deployed for EHE reporting and can be enhanced, as needed.

A statewide reporting system will need to be in place to meet CDC guidelines. The first steps in the evaluation plan will be:

- ADPH determining which CDC outcomes are relevant to the proposed strategic plan.
- Review of the current ADPH systems for data handling related to HIV prevention and treatment.
- Proposal for enhancing these methods, as needed.
- Establishment of a regional evaluation team to assist with assessment, capacity building plans, and TA, which may include using the Clinical Quality Measure (CQM) system or process monitoring.

CAPACITY

Although the strategic planning team is in the earliest phases of data collection and development, several themes relevant to evaluation are emerging. One particular challenge for ADPH will be ongoing data collection capacity of the agencies it serves to adequately inform the department's HIV program development plans. A diverse range in data collection capacity are seen regionally—urban versus rural regions—as well as by type of agency. For example, data handling strategies differ notably between university centers and small, local non-profits.

To accomplish an EHE program evaluation that is capable of accurately assessing progress and thus informing program planning, rigorous data collection needs to be accomplished at the agency level. Early steps in developing and implementing the evaluation will be to:

- Determine data handling requirements at the agency level.
- Assess data handling capacity of each agency.
- Develop regional capacity building plans.
- Provide TA, as needed.

CDC REQUIREMENTS

As part of the EHE Initiative, CDC offered a comprehensive set of outcomes asking states to monitor for assuring successful implementation and determine, most accurately, the impact of those interventions. Tables 1-4 in the appendix delineate CDC's proposed strategies and concomitant short-term and intermediate outcomes.

As can be seen, these are rigorous outcomes, many of which assume comparisons between a baseline and post-intervention changes. Part of the previously mentioned review of current data processes will include a determination of which of those data are already being collected.

Tables 5-8 expand on CDC requirements by adding information about what specific information would be required for the outcomes and the variables associated with those data. The "data" column operationalizes CDC outcomes, while the "variable" column offers more specifics. Variables further note where pre-intervention comparison groups are needed and where baselines need to be collected for comparison with what will be post-intervention statistics.

Finally, Tables 9-12 are set to show which data currently being collected will meet CDC requirements and what instruments or processes can be established to gather information that is either not being collected now or will be created post-intervention. These tables will be completed after the review of current data collection and processes are conducted. Those reviews will occur as the first steps of the implementation of the evaluation.

Selection of specific interventions to be included in the strategic plan will be done in collaboration with ADPH and community representatives, and will be informed by the needs assessment, which is currently in the data collection phase. The findings will be useful not only in planning, but also in providing baseline data on several of the proposed outcome parameters.

Evaluation planning will require the following:

- Completing data infrastructure review previously referenced.
- Incorporating needs assessment findings in the planning.
- Developing data collection instruments in collaboration with ADPH for outcome measures.
- Training regional evaluators, process monitors, and the CQM team, as required.
- Piloting instruments with a representative set of participating agencies.
- Launching data collection.

SUMMARY OF RECOMMENDATIONS

In summary, the following are recommended to initiate and complete the evaluation process:

Data Infrastructure

- ADPH determining which CDC outcomes are relevant to their proposed strategic plan.
- Reviewing the current ADPH systems for data handling related to HIV prevention and treatment.
- Proposing enhancements of these methods, as needed.
- Establishing a regional evaluation team to assist with assessment, capacity building plans, and TA by using the CQM system or process matters.

Capacity

- Determining data handling requirements at the agency level.
- Assessing data handling capacity of each agency.
- Developing regional capacity building plans.
- Providing TA, as needed.

CDC Requirements

- Completing data infrastructure review previously referenced.
- Incorporating needs assessment findings in planning.
- Developing data collection instruments in collaboration with ADPH for outcome measures.
- Training regional evaluators, process monitors, and CQM team, as required.
- Piloting instruments with a representative set of participating agencies.
- Launching data collection.

LIMITATIONS IMPOSED BY COVID-19 PANDEMIC

The initiation of EHE long predated the onslaught of the COVID-19 epidemic. Obviously, the exigencies of managing this pandemic has greatly burdened health departments, and necessitated an exceptional degree of flexibility among staff, agencies, and the public.

Data collection has been somewhat compromised by the stay-at-home policies; however, accommodations seem to be working. It is possible that the needs assessment process can be repeated in winter 2021 to further validate the findings and increase participation, if necessary.

The collaborators in the development of the EHE strategic plan and evaluation plan will include policies, methods, and recommendations that are as flexible as possible to implement. As the sequelae of the pandemic become more apparent, modifications can be applied.



APPENDICES

ACRONYMS

ADPH: Alabama Department of Public Health
ART: Antiretroviral Therapy
AIDS: Acquired Immunodeficiency Syndrome
ASO: AIDS Service Organization
BAO: Birmingham AIDS Outreach
BCL: Bureau of Clinical Laboratories
CBO: Community-Based Organization
CDC: Centers for Disease Control and Prevention
CHD: County Health Departments
CQM: Clinical Quality Measure
CBO: Community-based Organization
D2C: Data 2 Care
DIS: Disease Intervention Specialist
DVC: Domestic Violence Center
ED: Emergency Department
EHE: Ending the HIV Epidemic Initiative
EHR: Electronic Health Records
EPC: EHE Planning Committee
EPG: EHE Planning Group
FQHC: Federally Qualified Health Centers
GBM: Gay and Bisexual Men
HCC: HIV Cluster Committee
HCV: Hepatitis C Virus
HIV: Human Immunodeficiency Virus
HORT: HIV Outbreak Response Team
HRC: Human Rights Campaign
HRSA: Health Resources & Services Administration
HREP: HIV Re-engagement Program
HS: High School
JCDH: Jefferson County Health Department
LGBTQ: Lesbian, gay, bisexual, transgender, queer
MAO: Medical Advocacy Outreach
MSM: Men who have sex with men
NIC: not-in-care
OHPC: Office of HIV Prevention and Care
PHD: Public Health District
PrEP: Pre-Exposure Prophylaxis
PWH: Persons with HIV
PWID: People who inject drugs
RCC: Rape Crisis Centers
RWHAP: Ryan White HIV/AIDS Program
SANE: Sexual Assault Nurse Examiners
SSDI: Social Security Disability Insurance
SSI: Social Security Insurance
SSP: Syringe Services Program
STD: Sexually Transmitted Disease
TA: Technical Assistance
UA: The University of Alabama
UAB: University of Alabama-Birmingham
VA: Veterans Administration

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

December 15, 2020

CDC Grants Management Officer
Grants Management Branch Procurement,
and Grants Office
Centers for Disease Control and Prevention
2920 Brandywine Road
Atlanta, Georgia 30341-4146

Dear Officer:

The statewide planning group, End HIV Alabama, confirmed by consensus at its meeting on April 29, 2020, to concur with the following submission by the Alabama Department of Public Health (ADPH) in response to Funding Opportunity Announcement CDC-RFA-PS20-2010 - Integrated HIV Program for Health Departments to support Ending the HIV Epidemic in the United States.

The End HIV Alabama planning group is comprised of 82 voting members, 69 community representatives, and 13 governmental representatives. In addition to the Office of HIV Prevention and Care staff, 6 ADPH district HIV managers, and 1 to 2 representatives from the 13 AIDS Service Organizations (ASOs), community liaisons were identified by the HIV managers and ASOs at community focused events such as local HIV Prevention and Care Group meetings, town hall meetings, and focus groups.

This letter of concurrence meets the requirements of the Ending the HIV Epidemic Plan, is submitted on behalf of the End HIV Alabama planning group, and is signed by the ADPH co-chair and community co-chairs. These chairs have been designated as signatories to the letter of concurrence.

Agreed and accepted,

ADPH Co-Chair

Community Co-Chair

Community Co-Chair

Community Co-Chair

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Table 1 – Ending the HIV Epidemic (EHE) Strategy: Diagnose

Strategies and Activities	Strategies and Activities	Intermediate Outcomes	Measures	Data	Variables
1. Expand or implement routine opt-out HIV screening in healthcare and other institutional settings in high prevalence communities. 2. Develop locally tailored HIV testing programs to reach persons in non-healthcare settings. 3. Increase at least yearly, re-screening of persons at elevated risk for HIV, per CDC testing guidelines in healthcare and non-healthcare settings.	1.1 Increased routine opt-out HIV screenings in healthcare and other institutional settings. 2.1 Increased local availability of and accessibility to HIV testing services. 3.1 Increased HIV screening and re-screening among persons at elevated risk for HIV.	3.1 Increased knowledge of HIV status. 3.2 Reduced new HIV diagnosis.	1.1 Percentage of health care facilities identified as priority for opt-out HIV screening. 1.2 Percentage of persons tested in health care facilities identified as priority for routine opt-out screening. 2.1 Of all tests conducted in the community, the percentage conducted in other venues identified as a priority for the alternative EHE HIV testing services. 2.2 Percentage of all persons tested linked to appropriate HIV medical care and prevention services. 3.1 Percentage of people with HIV ≥ 13 years of age who know their serostatus (EHE target: ≥ 95% by 2025). 3.2 Number of diagnoses among persons aged ≥ 13 years old during the measurement period.	1.1 Baseline and annual number of facilities offering opt-out testing. 1.2 Baseline and annual number of high-priority testing conducted. 2.1 Baseline and annual number of tests conducted in alternative facilities. 2.2 Baseline and annual number of completed referrals. 3.1 HIV incidence per community per demographic categories.	1.1 Facility and type 1.2 Location 1.3 Tested clients' demographics 1.4 Percentage change in testing 1.5 Risk identified 1.6 Number of tests and intervals per client 2.1 Facility and type 2.2 Location 2.3 Tested clients' demographics 2.4 Percentage change in testing 2.5 Number of tests and intervals per client 2.6 Agency referred to 2.7 Percentage change in completed referrals 3.1 Statistical model of likely number of cases, per community 3.2 HIV Epidemiology report 3.3 Newly diagnosed cases 3.4 Difference between theoretical number and report of new cases 3.5 Number of incident cases in study interval

Table 2 – Ending the HIV Epidemic (EHE) Strategy: Treat

Strategies and Activities	Strategies and Activities	Intermediate Outcomes	Measures	Data	Variables
1. Ensure rapid linkage to HIV medical care and anti-retroviral (ART) initiation for all persons diagnosed with HIV. 2. Support re-engagement and retention in HIV medical care and treatment adherence, especially for persons who are recipients of the Ryan White HIV/AIDS Program.	1.1 Increased rapid linkage to HIV medical care. 1.2 Increased early initiation of ART. 2.1 Increased immediate re-engagement to HIV prevention and treatment services to persons living with HIV (PLWH). 2.2 Increased support to providers for linking, retaining, and re-engaging PLWH to care and treatment.	2.3 Increased receipt of HIV medical care among PLWH 2.4 Increased viral suppression among PLWH.	1.1 Percentage linked to HIV medical care. 1.2 Percentage of PLWH ≥ 13 years of age in the measured period and with viral suppression ≤ six months after HIV diagnosis (EHE target: ≥ 95% by 2025). 1.3 Percentage of presumptively not in care (NIC) PLWH with an investigation opened during the specified six-month evaluation time, who were confirmed within 90 days after the investigation was opened not to be in care. 1.4 Percentage of PLWH confirmed, during a specified six-month evaluation time not to be in care, who were linked to HIV medical care waiting 30 days after being confirmed to not be in care. 1.5 Percentage of PLWH linked to HIV medical care, during a specified six-month evaluation time, who achieved HIV viral suppression within six months after being linked to care. 2.1 Percentage of PLWH > 13 years of age who received any HIV medical care as measured by documentation of > 1 CD4 or viral load tests performed during the measurement period (EHE target: 95% by 2025). 2.2 Percentage of PLWH > 13 years of age who are virally suppressed at last test.	1.1 Number of HIV tests in study interval. 1.2 Number of referrals per positive test. 1.3 Number of completed referrals. 1.4 Number of incident cases in people ≥13 years of age. 1.5 Number who initiate ART. 1.6 Viral load at baseline at six-months post diagnosis. 2.1 Number of investigations of persons deemed to be NIC. 2.2 Recording of time interval for determination of case status. 2.3 Percentage of PLWH confirmed, during a specified six-month evaluation time NIC and who were linked to HIV medical care waiting 30 days after being confirmed that they are NIC. 2.4 Percentage of PLWH linked to HIV medical care, during a specified six-month evaluation period and that achieved HIV viral suppression within six months after being linked to care. 2.5 Number of persons in care. 2.6 Number of CD4 tests. 2.7 Baseline and test period. 2.8 CD4 and viral load statistics.	1.1 Percentage of completed referrals. 1.2 Difference in percentages over time intervals. 1.3 Incident cases per locality. 1.4 Percentage who initiate ART. 1.5 Differences in viral load changes against a control group. 1.6 Differences in rates of ART initiation against a control group. 2.1 Frequency of out of care PLWH, per community. 2.2 Percentage of PLWH receiving evaluations at six months. 2.3 Average and range of time to determine care status. 2.4 Difference in range of time to determine status between study and control group. 2.5 Frequency of referrals to HIV medical care. 2.6 Percentage of completed referrals. 2.7 Time to completion of referral to care. 2.8 Percentage difference in viral load calculations at baseline. 2.9 Percentage difference in viral load calculations at the six-month evaluation. 2.10 Duplicated and unduplicated medical service units, per community, compared to a comparison time. 2.11 Average and range of CD4 counts. 2.12 Differences in CD4 counts, per community, compared to a comparison time period. 2.13 Differences in viral load statistics, per community, compared to a comparison time period.

Table 3 – Ending the HIV Epidemic (EHE) Strategy: Prevent

Strategies and Activities	Strategies and Activities	Intermediate Outcomes	Measures	Data	Variables
1. Accelerate efforts to increase pre-exposure prophylaxis (PrEP) use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP. 2. Increase availability, use, and access to quality of comprehensive syringe programs (SSPs).	1.1 Increased screening for PrEP indications among HIV-negative clients. 1.2 Increased referral and linkage of persons with indications for PrEP. 2.1 Increased access to SSPs.	1.1 Increased PrEP prescriptions among persons with indications for PrEP. 2.1 Increased knowledge of services and evidence-base of SSPs in communities. 2.2. Increased quality of evidence-based SSP services.	1.1 Number of HIV negative clients who are screened for PrEP. 1.2 Number and percentage of HIV negative clients who are linked to PrEP. 1.3 Number of persons prescribed PrEP among those with indications for PrEP. 1.4 Percentage of persons using PrEP (defined as filled prescriptions) among those with indications for PrEP (EHE target: ≥ 50% by 2025. 2.1 Number of SSP delivery sites.	1.1 Number of HIV negative clients. 1.2 Number screened for PrEP. 1.3 Number of persons offered PrEP. 1.4 Number of PrEP prescriptions. 1.5 Number of PrEP prescriptions filled. 1.6 Reasons for failure to fill prescriptions. 2.1 Number of SSP sites. 2.2 Number of relevant service providers. 2.3 Reasons for failure to offer SSP. 2.4 Baseline knowledge of SSP. 2.5 Post-intervention knowledge of SSP.	1.1 Percent of client population considered at risk for HIV. 1.2 Frequency of each risk category within client population. 1.3 Percentage of at-risk groups screened for PrEP. 1.4 Differences between study population statistics and comparison group. 1.5 Percentage of at-risk groups offered PrEP. 1.6 Frequency of PrEP prescriptions filled. 1.7 Percentage of PrEP prescriptions filled. 1.8 Percentage of reasons for failure to fill prescriptions. 2.1 Percentage of current service providers offering SSP. 2.2 Frequency of new sites offering SSP. 2.3 Percentage of reasons for failure to offer SSP. 2.4 Differences between study population statistics and comparison group. 2.5 Differences in scores on SSP knowledge assessment.

Table 4 – Ending the HIV Epidemic (EHE) Strategy: Respond

Strategies and Activities	Strategies and Activities	Intermediate Outcomes	Measures	Data	Variables
1. Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response. 2. Investigate and intervene in networks with active transmission. 3. Identify and address gaps in programs and services revealed by cluster detection and response.	1.1 Increased health department and community engagement for cluster detection and response. 2.1 Improved surveillance data and data systems for real-time cluster detection and response. 3.1 Improved policies and funding mechanisms to respond to and contain clusters and outbrea	3.1 Improved knowledge of networks to contain HIV transmission clusters and outbreaks. 3.2 Improved response to HIV transmission clusters and outbreaks.	1.1 Number of committee guide cluster response meetings, which will be held at least quarterly. 1.2 Number of meetings per year with a wide range of community members to engage them in cluster response, which must be held at least quarterly. 1.3 Number of agreements for CBOs to be involved in cluster response. 2.1 Of all diagnoses, the percentage entered into the local surveillance system within the time specified in the HIV surveillance guideline. 2.2 Of all diagnoses, the percentage of duplicates identified in the Soundex application prior to entry into the surveillance system. 2.3 Of all labs with specimen collection dates in the reporting year, ≥ 85% are entered into the surveillance system within two weeks of the specimen collection data. 3.1 Number and percentage of persons in the cluster network who were located and interviewed within seven days of identification as part of a cluster.	1.1 Number of standing committee meetings in study interval. 1.2 Previous meeting frequency. 1.3 Meeting agendas 1.4 Meeting participants. 1.5 Number of CBO contracts executed or extended, during study period. 2.1 Incident cases in study period. 2.2 Number of cases entered into Soundex and the local surveillance system. 2.3 Dates of data entry into specimen collection system. 3.1 Estimation of the number in cluster network. 3.2 Number in cluster located. 3.3 Number in cluster interviewed. 3.4 Dates of location and interview.	1.1 Differences in the number of standing committee meetings during the study interval and previous 24 months. 1.2 Differences in the number and demographics of committee attendees, during the study interval and previous 24 months. 1.3 Themes and issues emerging from meetings. 1.4 Difference in the number of CBOs involved in cluster response, during the study interval and previous 24 months. 1.5 Differences in the types of CBOs involved in cluster response, during the study interval and previous 24 months. 2.1 Differences in percentages of cases entered into local surveillance system during the study interval and previous 24 months. 2.2 Differences in percentages of cases entered into Soundex and the local surveillance system, during the study interval and the previous 24 months. 2.3 Differences in percentages of cases entered into the specimen collection system, during the study interval and previous 24 months. 3.1 Differences in percentages of persons in cluster network who are located, during the study interval and previous 24 months. 3.2 Differences in lag time in interviewing persons located in cluster networks, during study interval and previous 24 months.