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)

DEDICATION

The Ending the HIV Epidemic Alabama Plan is dedicated to all Alabamians living and thriving with HIV and AIDS. This plan is also dedicated in memory of our fellow Alabamians and those worldwide who have lost their lives, due to the complications associated with HIV or AIDS. In their honor, the EHE Plan raises the bar for intentionality; individual and collective response for action, Alabamians taking ownership to help reduce the impact of HIV and more significantly, eradicate HIV in our communities. This unified commitment is signified by the collaborative spirit of all who contributed countless hours in sharing their stories, thoughts, and experiences to bring life to the EHE Alabama Plan. Alabama's Plan, a living document, strives to capture the essence of the Ending the HIV Epidemic: A Plan for America towards reaching the national 2025 and 2030 goals. The time is NOW!

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ACKNOWLEDGMENTS

EHE Leadership Team

Adrinda Carter, MPH, Acting Director EHE Program Branch, Office of HIV Prevention and Care (OHPC), Alabama Department of Public Health (ADPH)

Laurie Dill, MD, AAHIVS, Medical Advocacy and Outreach (MAO)

Allison Hatchett, MPH, former Director Ryan White Part B Program Division, OHPC, ADPH

Scott Harris, MD, MPH, FACP, FIDSA, State Health Officer, ADPH

David Hicks, DO, MPH, FAAFP, Deputy Health Officer, Jefferson County Health Department (JCHD)

Sharon Jordan, MPH, Director OHPC, ADPH

Vontrese McGhee, MBA, Director Ryan White Part B Program Division, OHPC, ADPH

Mary McIntyre, MD, MPH, SSBB, Chief Medical Officer, ADPH

Michael Mugavero, MD, MHSc, Co-Director, University of Alabama at Birmingham Center for AIDS Research

Michael Murphree, LCSW, Chief Executive Officer, MAO

Jitesh Parmar, MPH, Chief Financial Officer, Thrive Alabama

Jora White, MA, Director HIV Prevention Division, OHPC, ADPH

EHE Committees

Advocacy and Legislative Committee
Branding and Marketing Committee
Education Committee
Membership Committee

Thank you to those who helped conduct the community needs assessment, facilitate the plan development, organize and facilitate town hall meetings and focus groups, and the plan compilation.

Office of HIV Prevention and Care, Alabama Department of Public Health
Alabama Partners for Health, Inc.
Claris Advocates
Human Rights Campaign Alabama
Mark Moore Creates LLC

ACKNOWLEDGMENTS

EHE Alabama Partner Organizations as of December 9, 2020:
Would you like to become a partner?
Email us at Chelsey.holland@adph.state.al.us or jonathan.joseph@adph.state.al.us

2nd Chance, Inc.
AIDS Alabama
AIDS Alabama South
Alabama A & M University
Alabama Coalition Against Domestic Violence
Alabama Coalition Against Rape
Alabama Department of Public Health
Alabama Department of Rehab Services
Alabama Partners for Health, Inc.
Alabama Regional Medical Services
Auburn University
Birmingham AIDS Outreach
Capital City Gastroenterology
Central Alabama AIDS Resource & Advocacy Center, Inc.
City of Montgomery
Claris Advocates
Crisis Center, Inc., Rape Response and SANE
Crisis Services of North Alabama
Dumas Wesley Community Center
East Alabama Medical Center
Family Services of North Alabama
Family Sunshine Center
First Methodist Church
Five Horizons Health Services
Franklin Primary Health Center
GoodWorks: North Alabama Harm Reduction
Health Services Center of Alabama
Human Rights Campaign Alabama
Jefferson County Health Department
Lifelines Counseling Services
Medical Advocacy Outreach
Mental Health Association in Morgan County
New Salem Christian Church
One Place of Shoals
Rape Counselors of East Alabama, Inc.
Rehab Select
Resource and Advocacy Center
Safehouse of Shelby County
Selma AIR
Shoals Crisis Center
Southern AIDS Coalition
Teens Empowerment Awareness with Resolution, Inc.
The House of Ruth, Inc.
The Knights and Orchids Society
The Lighthouse
The University of Alabama
The University of Alabama Medical School
The University of Alabama Project Health
Thrive Alabama
Turning Point
Tuscaloosa Diversion Department
Tuscaloosa SAFE Center
University Wellness Center
University of Alabama – Birmingham (UAB)
UAB 1917 Clinic
Victim Services of Cullman, Inc.
Whatley Health Services

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:

Adrinda Carter, Acting Director EHE Program Branch, ADPH, adrinda.carter@adph.state.al.us

Carmarion D. Anderson-Harvey, State Director, Human Rights Campaign (HRC) Alabama, carmarion.anderson@HRC.org

Shey Thomas-Thorn, Interim Co-Executive Director, AIDS Alabama South, shey.thorn@aidsalabama.org

Tony Christon-Walker, Director of Prevention and Community Partnerships, AIDS Alabama, tony.walker@aidsalabama.org



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.

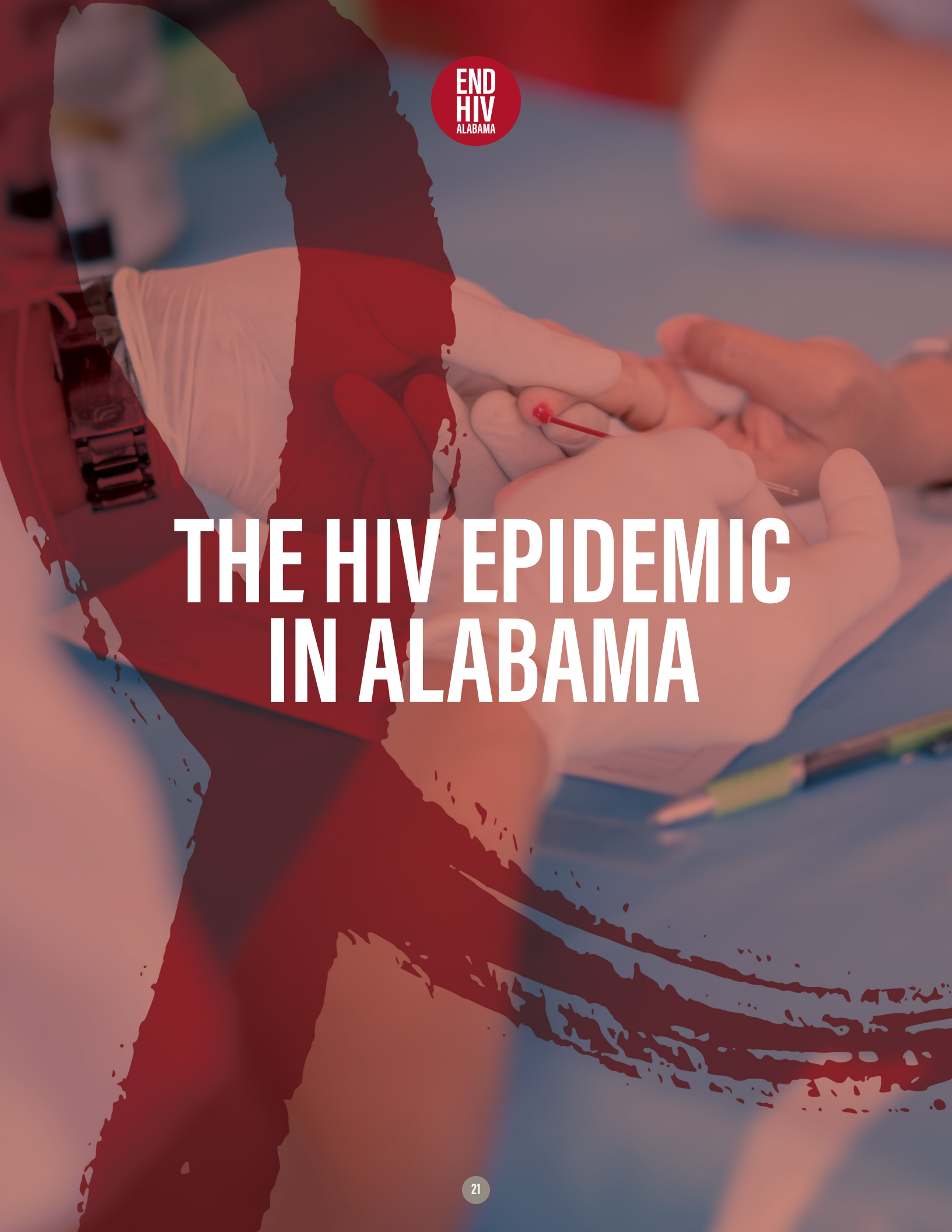
Stakeholders and Key Informants Who Were Not Involved but Are Needed

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

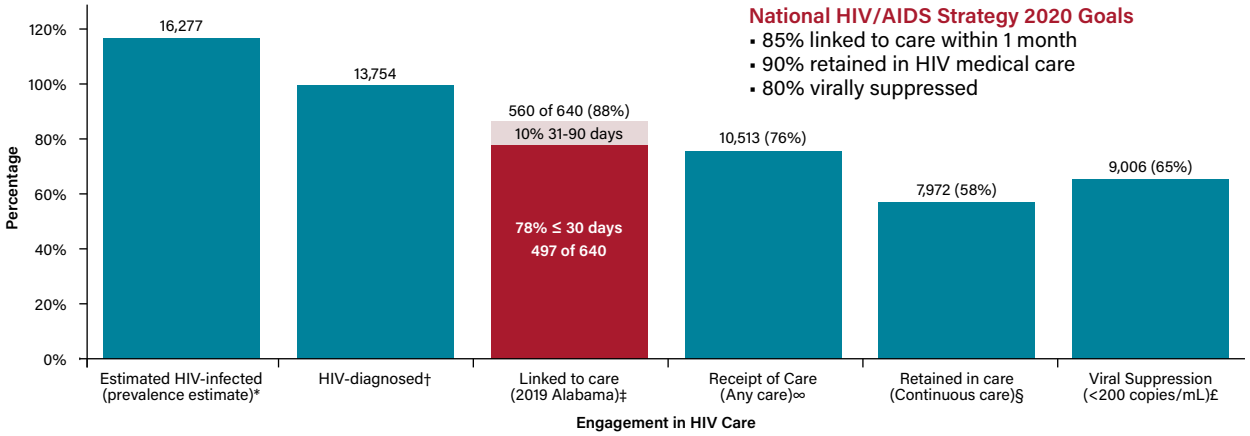
* (does not include “unknown”)

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:

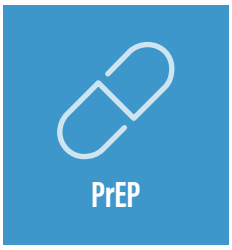
- Reduce stigmatizing.
- Improve access to accurate, culturally-appropriate, timely information about sexual health information and HIV.
- Increase the resource base for public health, agencies and individuals.
- Culturally-appropriate care.

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

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

PHAB
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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.

SITUATIONAL ANALYSIS

INTRODUCTION

Efforts to end the epidemic of HIV have been conducted for nearly 40 years. Strategies have been developed that have resulted in remarkable progress in core public health, healthcare, mental healthcare, and prevention sciences. However, the number of HIV cases continue to rise from relatively low but consistent rates in some regions, to alarmingly high rates in outbreaks in others. Monica Gandhi, co-chair of the United Nations Program on HIV/AIDS, reported to the 20,000 HIV specialists, PWH, and activists who attended the program's biennial meeting, that:

> *"We know how to treat, we know how to prevent, we know how to get to zero, we know how to do it. We need more political will. We need more commitment."*[1]

Gandhi also addressed the unique challenges of 2020 when the public health infrastructure that had been honed in addressing HIV was significantly stressed by the COVID-19 pandemic. At the same meeting, participants worried that COVID-19 would put PWH at particular risk as lockdowns, pressures on public health, hospital and healthcare resources limited their access to treatment, prevention measures, loss of income and medical insurance.

Systemic challenges, all too familiar to the HIV prevention and treatment communities, have been exacerbated in this new assault. As noted by Julia Marcus, an infectious disease epidemiologist at Harvard Medical School, the missteps in the US response to COVID-19 reflect that

> *"chronic underfunding of public health neutered the nation's ability to prevent the virus from taking hold. A bloated, inefficient health-care system left hospitals ill- prepared for the ensuing wave of sickness. Racist policies that have endured since the days of colonization and slavery left Indigenous and Black Americans especially vulnerable to COVID-19."*[2]

It is in this unexpected context that HIV must still be addressed. 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, HRSA, Indian Health Service, National Institute of Health, Office of the Assistant Secretary for Health and the Substance Abuse and Mental Health Services Administration. According to Phillps2, the EHE initiative will be implemented to

> *"reduce the number of new HIV infections in the US by at least 90 percent by 2030—even in the midst of the COVID-19 pandemic."*[3]

SUCCESS WILL BE MEASURED BY PROGRESS IN SIX KEY INDICATORS:

- HIV incidence
- Knowledge of HIV status
- HIV diagnoses
- Linkage to HIV medical care
- Viral suppression
- PrEP coverage

EHE is structured to meet these indicators with recommended strategies and outcomes in four categories.

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 EHE Planning Group (EPG) of statewide stakeholders who will participate in every phase of developing a strategic plan to meet the requirements of the EHE initiative. The first step in that process was the commissioning of a needs assessment. This document is a report of the findings from that project.

METHODS

INSTRUMENTS AND PROCESS

The needs assessment was conducted by the **Alabama Partners for Health, Inc.,** a healthcare consulting firm specializing in health policy support and analysis, from March through July 2020. Due to the exigencies of the COVID-19 pandemic, the planned data collection methods were seriously compromised. The intent was to gather data as follows:

1. Surveys
    a. EHE (Client Survey)
        - for PWH
        - Spanish and English options
    b. Alabama Health Needs Assessment (Community Survey)
        - for community members
        - Spanish and English options
2. Focus groups
    a. community members
    b. ASO service providers
    c. peer counselors
3. Interviews
    a. healthcare providers
    b. mental healthcare providers
4. Community stakeholder dialogues
    a. monthly meetings with ADPH staff and service providers

Unfortunately, due to COVID-19, none of the data collection methods were available for in-person meetings. All focus groups and stakeholder meetings were carried out virtually via Zoom. Interviews were conducted via telephone and survey participants were recruited by agencies' data collection teams using social media and service provider contact. When possible, some providers arranged to distribute $25 gift cards; however, contact restrictions made their distribution inconsistent across agencies and regions.

Data collection processes and survey instruments as well as questions for both the focus groups and interviews were reviewed and approved by a group of stakeholders prior to the launch. Surveys were administered confidentially and were de-identified prior to analysis.

Questions in each of the data collection instruments were targeted to the EHE topics, as shown in the following table.

Table 2

	PREVENTION	DIAGNOSE	TREAT	RESPOND
EHE Survey	✓	✓	✓	
AL Health Needs Assessment	✓	✓		
Focus Groups	✓	✓	✓	✓
Interviews	✓	✓	✓	✓
Stakeholder Meetings	✓	✓	✓	✓

PARTICIPANTS

All focus groups and interview participants were accommodating and forthcoming and this component of the data collection was not compromised. Unfortunately, the most serious effect on the data collection process was the limited method of recruiting survey participants and the resultant relatively low sample size in each.

That impact is apparent, especially, in the low number of Spanish survey respondents and in the underrepresentation of transgender people in the survey. To compensate for these issues, focus groups were added specifically for transgender service providers and another for Spanish-speaking ASO clients.

Table 3

	English		Spanish	
EHE Survey	73		20	
AL Health Needs Assessment	213		10	
Focus Groups	8 groups	33 participants	1	5 participants
Interviews	7		0	
Stakeholder Meetings	4 (as of 8/1)	73+ participants	interpretation provided, as requested	

LIMITATIONS

As indicated, the number of surveys fell below the planned targets. The intent of the needs assessment team is to launch the process again once the COVID-19 pandemic subsides. Prior to the relaunch, the instruments will be reviewed based on the response rate from the 2020 study. Questions will be added or deleted, based on what will be current needs and the likelihood that they will be administered by trained data collectors.

The information collected in this iteration can be interpreted to be valid, and assumed to be reliable, which will be confirmed in the follow up relaunch. This future study will oversample both transgender persons and those who are Latinx. Future data collection will also attempt to reach more people who previously or currently have opted out of HIV treatment.

DATA HANDLING AND ANALYSIS

Focus groups and stakeholder meetings were recorded via Zoom and professionally transcribed, while interviews were annotated by the interviewer. Surveys were administered via a Survey Monkey link and 20 were distributed in hard copy by an ASO provider.

Focus group, stakeholder meeting, and interview data were de-identified and then coded using Dedoose. Survey data were collected using Survey Monkey and analyzed using SPSS version 26. All data are stored in a dedicated, encrypted hard drive owned by the data analyst.

STRUCTURE OF THE REPORT

The following report is divided into six sections that reflect the overall themes, the EHE topics, and special topics that emerged from the data collection.

1) Overall themes
2) Prevention
3) Diagnosis
4) Treatment
5) Response
6) Special Topics

Each of these is divided into subsections:

1. Overview, that defines terms and lists the topics to be covered.
2. Topics
    a. Observations, that details the insights gleaned from the focus group, stakeholder meetings and interview.
    b. Findings from the surveys.

Appendices include both surveys in English and Spanish and links to the presentations that were created from the data found in this report. In addition, demographics for the respondents to all four of the surveys are included.

Quotes that were drawn from the interviews and focus groups are included throughout the document and represent as balanced a mix as possible of those offered by healthcare and service providers, as well as clients. Since participants were assured that their comments would be confidential, they are not attributed. Bracketed phrases within quotes were added to enhance clarity, when necessary.

RESULTS

RECURRING THEMES

In the groups and interviews, as well as in the *Comments* sections of the surveys, several themes emerged that transcended the four EHE topics and seem to inform each of them. They centered on barriers to accessing prevention and treatment services. The themes though treated distinctly for clarity, were often presented by respondents in a way that suggested that they were interwoven. The themes were:

- Stigma
- Education
- Lack of resources
- 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. Others were reported to underestimate their risk of infection because they are not "those people." One participant noted,

> *"People don't want to come for testing because of too much stigma. I think people believe that needing to be tested is associated with loose morals and being promiscuous."*

External stigma experienced by clients, according to participants, as the perceived judgment that they encounter when seeking care. Fearing exposure to such judgement, they recoil from taking health promoting behaviors. A participant articulated this as especially true for LGBTQ+ clients:

> *"It's hard finding someone who is actually affirming you. It's like you work yourself up to get the energy to go to a doctor to find care or prevention and ...find out that everybody on the staff is transphobic or homophobic. That doesn't make you want to go back to that facility at all. And that word gets on the street. People get tired of being triggered."*

This perceived stigmatizing is further expressed as concern about the potential of disclosure of test results by providers, regardless of how scrupulous an agency or clinician might be to protect clients. Participants confirmed that this concern is so pervasive that clients fear even being seen at testing or treatment sites.

> *"Clients told us that if you wanted to know who was positive, you would ride by the clinic on the day they are giving out medicine. They always ask, 'is this going to be anonymous?' I know this still plays a role in the stigma about getting test because [they think] there are no safety [measures] in place."*

Survey data further explored these themes. On the Community Survey (English version), 21 percent of respondents ranked "stigma" as second only to cost of services as a barrier to seeking care. For Latinx respondents, stigma was the greatest barrier (30 percent). For 13 percent of respondents on the English survey, fear of judgment by providers was listed as a barrier.

Stigma, thus, appears to inhibit relevant discussions with sexual partners, prevent those at-risk from acquiring accurate information to protect themselves from infection and allow entire communities to suppress access to needed services.

According to participants, one of the more effective ways to counter stigma is for clients, providers, and the community at large to have access to and to effectively assimilate accurate, targeted, and clear information, which they codified as "education."

RECOMMENDATIONS

To counteract the impact of stigma, participants recommended:

- 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. The respondents defined education as dissemination of accurate, thorough and culturally relevant HIV-related information about prevention and treatment. Many lamented that they could identify no segment of the community-at-large, including those health care providers who are not directly involved in HIV services, who were consistently, accurately informed about HIV risk factors, prevention options, and treatment protocols.

> *"Like I said 'lack of education,' they [community members] are still on what Oprah said 20 years ago. They don't want to know anything else."*

Within the general populace, respondents noted that residents, especially in rural arears, 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. While CHDs were identified as information sources, the recent discrediting of public health during the COVID-19 pandemic has the potential of eroding trust in prevention-related messaging. They noted, too, that potential clients fear health departments because of experiences they may have had with county offices or other government agencies.

> *"So, I think the role [of health departments] is so established: intervention and educating the public about the dangers or the risks of HIV, as well as other infectious diseases. But I think the Health Department is significantly attached to being a county agency, that people would rather not access services there."*

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, if they are even willing to broach such an assessment. Some, it was reported, were insufficiently apprised of risk assessment and PrEP details for those seeking prevention methods or the viral suppression potential. Patients were also insufficiently apprised of the protocols associated with ART.

> *"I learned an important lesson in internal medicine practice before I came here. I made assumptions about patients' risk and learned I was very wrong. It is something I carry with me now. HIV testing is important for peace of mind and to capture the true prevalence of HIV."*

Healthcare providers were also challenged by assessing the relevant psychosocial aspects of medical regimen adherence, which can be more challenging for PWH or those at risk. The exigencies of busy community-based practices can prohibit the thorough review of the non-medical components of patients' lives that can significantly affect their ability to engage in effective prevention or where it's needed, to initiate or maintain HIV treatment. The respondents underscored, how important such information can be.

> *"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."*

Regional differences in access to information were also cited and tied to disparities in individuals pursuing health promoting behaviors. Every one of the challenges facing PWH or those at risk, are exacerbated in rural areas. This participant discussed the near-crisis conditions they face:

> *"If we look at per capita rates in Black Belt counties, people are at risk just based on geography. There needs to be a creative, county-level, trust building, grass roots campaign. Need creative political will. We need to keep an eye on ending the epidemic in rural areas due to more stigma, lack of insurance, lack of access, transportation issues and poverty. It is going to take increased efforts to build trust, test, and educate in Alabama's rural counties"*

Information, they believe, must be contextualized and tied to the specific behaviors associated with effective prevention or adherence to treatment and furthermore, it must be framed to the mores of the area. To actuate change, in addition to accurate information, health promoting peer supporters and opinion leaders were needed, especially in rural areas to model prevention behaviors.

> *"Clinic directors should include the peer [mentors]. We know social workers are overwhelmed, we [peer mentors] should make home visits, well-checks, be honest with them (about our own struggles) and keep them in care. If they don't feel empathy and compassion, we should take more time with them."*

RECOMMENDATIONS

Following the insight about tailoring of messaging and deployment of peers, respondents stressed that to be most effective, education programs for both providers and community members must:

- Enact best practices
- Provide bio-psychosocial and intersectional components of health and health disparities
- Provide gender-affirming care
- Normalize and de-stigmatize prevention and treatment
- Conduct 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 that are intersectional in etiology as has rarely been more obvious than now.

As noted earlier, COVID-19 has underscored the impact of chronic underfunding of the public health infrastructure and of agencies that service the public health and psychosocial needs of the community. Most apparent are the deprivations and limits to resources faced by individuals, especially people of color, rural residents, immigrants, and the LGBTQ+ community. persons that identify as being LGBTQ+.

HIV programs administered by the state's health department, ASOs, and CBOs have struggled to address the more serious needs of their clients with sporadic resources. States that expanded Medicaid under the ACA 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 in some parts of the state, adolescents need to travel as much as 35 miles for services. For example, PrEP clinics are few in the state and as discussed in the sections above, some clinics face threats of closure because of lack of community financial or cultural support.

"There is a huge need for mental health, legal assistance, immigration services... We really need more funds to educate and really help our community. I believe that the message needs to be that we need more resources to have comprehensive care."

At the individual level, many clients struggle with significant lack of financial resources. Survey data showed that across the 4 surveys, 5.3 percent of respondents were homeless, another 4.4 percent considered their housing to be unstable and 12.3 percent frequently experienced food shortages. Nearly one-third (32.4 percent) reported annual income under $10,000 and 15.3 percent do not have health insurance.

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. The impact of these conditions is blatantly expressed by a respondent:

"Although I think it comes down to their priorities. A lot of times, their priorities don't align with the folks that they're serving. Understand that if you're going to serve high-risk, low income, rural Black folks, who are queer and trans, you're probably going to have to include health access. We just don't have the extra $300 sitting around in a sock somewhere to pay for insurance."

Providers who participated in the focus groups and interviews underscored the challenges faced by their clients. They 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 of the participants, most often from those who served in rural areas. The providers 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.

"Affordability [of medications is a problem]. A lot of times, people don't know that those things [medication discount programs] even exist."

RECOMMENDATIONS

Combating these resource limits requires action at every level - public policy changes; resource allocation and prioritization for healthcare and social service agencies; and opportunities and support for individuals. Respondents made several 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 was a recurring theme among the respondents in the groups, interviews and surveys. The lack of such services was among the most relevant and impactful barrier.

"Studies even show that because of a lack of affirming care, people would rather not go to the doctor. We'll figure it out on the street. People get tired of being triggered."

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 whose care can be complicated and compromised by homophobia and transphobia.

> *"[It's an] issue of safety; it's hard finding someone who is actually affirming you. It's like you workup yourself to go to a doctor to try and find care or prevention just to get to the doctor's office to find out that everybody in the staff is transphobic or homophobic. That makes you not want to go back to that facility at all."*

These conditions are very consequential. According to the CDC, of the "37,832 new HIV diagnoses in the US and dependent areas in 2018:

- 42 percent were among adults and adolescent African-American/Blacks
- 31 percent were among African-American/Black men
- 11 percent were among African-American/Black women"[6]

In Alabama, though they comprise only 25.4 percent of the population, ADPH statistics show that of new cases, African-American/Blacks represented

- 70.6 percent were among adults and adolescent African-American/Blacks including
  - 70.1 percent of males
  - 72.9 percent of females
- 69.9 percent of the prevalent cases

CDC statistics from 2016 showed that in the US, for every 100 African-American/Black PWHs

- 61 percent received some HIV care
- 47 percent were retained in care
- 48 percent were virally suppressed[6]

The 2014 statistics for Alabama reveal that every for African-American/Black PWH

- 78 percent received some HIV care within 90 days
- 55 percent were retained in continuous care
- 59 percent were virally suppressed[7]

African-American/Black survey respondents reported several indicators of poverty that put them at risk for worse health outcomes, as seen in the following table.

Table 4

POVERTY INDICATORS IN AFRICAN- AMERICAN RESPONDENTS	PWH		Community	
	#	percent	#	percent
Annual Income Less Than $10,000	19	38.8	63	44.4
Unstable Housing	7	14.3	28	19.7
Food Insecurity	14	28.6	52	36.6
No Insurance*	20	40.8	18	12.7
Total	49	100.0	142	100.0

*Insurance = for PWH at diagnosis, and for Community at the time they completed survey

Participants in both groups and interviews validated these findings They attributed these factors to the themes already addressed, as well as the systemic racism that still exists even in the delivery of healthcare.

"There needs to be a creative, county-level, grassroots, trust-building campaign. We need creative political will. We need to end the epidemic in rural areas and [address] stigma, lack of insurance, lack of access, transportation and poverty."

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.

Most people of color and other members of marginalized groups are adversely affected by these disparities, systemic racism, and culturally-inappropriateness. 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.



OVERVIEW

Despite extraordinary advances over the course of the HIV pandemic in understanding the bio-psychosocial factors associated with HIV risk, cases continue to rise. The table below lists the indicators and interventions that are recommended by the CDC to produce the intended EHE prevention outcomes.

Table 5

CDC CATEGORY	INDICATORS	OUTCOMES
PREVENTION	▪ HIV incidence ▪ PrEP coverage	▪ Increased screening for PrEP indications among HIV- clients ▪ Increased referral and rapid linkage of persons with indications for PrEP ▪ Increased PrEP prescriptions among persons with indications for PrEP ▪ Increased knowledge about the evidence-base of SSPs ▪ Increase quality of SSP services

The needs assessment queried respondents on the following topics related to prevention:

- General strategies that support HIV prevention
- Barriers to prevention
- Risk assessment
- PrEP
- SSP

OBSERVATIONS FROM GROUPS AND INTERVIEWS

GENERAL STRATEGIES THAT SUPPORT PREVENTION

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 also needs more information in general about HIV and prevention methods. To facilitate these suggestions, respondents stressed that testing needed to be normalized by inclusion in more of the points of contact between the public and healthcare providers. Advance testing required more health-related marketing.

> *"I think the more people know, the easier it is [for them] to understand [prevention messages]. You feel a lot less anxiety around testing once you have more information about what's happening, how it's contracted, and treatment. All those things. Not just knowing about prevention but knowing about care and treatment. Because a lot of times, we fear things that we're not familiar with. So, just educating people more and also normalizing testing."*

Another strategy proposed by a healthcare provider was the possibility of more frequent contacts between persons-at-risk and their providers.

> *"I think that seeing patients every 3 months is helpful, nationally people stay on for 6-12 months and feel they no longer need it. A study has shown maybe seeing younger and higher risk patients more often may help."*

The respondents told interviewers that enhanced frequency could be accomplished by incorporating HIV prevention messages across healthcare and social science disciplines. Appointment for WIC services, other healthcare, mental health care, and substance abuse treatment programs were determined to be excellent venues in which HIV prevention messages could be embedded.

> *"We have several rehabilitation substance abuse facilities. HIV sexual health should be taught there. Every organization that should be included or incorporated into their curriculum."*

The survey data provided information about what prevention measures the respondents were most likely to take. The most acknowledged prevention behavior reported in both surveys was limiting the number of sex partners (N=115, 55 percent (English) and N=7, 70 percent (Spanish).

Very few indicated use of PrEP (N=17, 3 percent and 0), however, PrEP use among those who were single were higher: 9.7 percent (N=12) and 13.9 percent (N=5). For single respondents, condom use rose to 62.1 percent (N=77).

Table 6

PREVENTION MEASURES	English		Spanish	
	#	percent	#	percent
HIV Testing	104	49.8	2	20.0
STI Testing	84	40.2	0	0
Know Partner Status	115	55.5	1	20.0
Limit Number Of Partners	125	59.8	7	70.0
Use Condoms	113	54.1	2	20
Use Prep	17	8.1	0	0
Abstain From Sex	10	4.8	0	0
Total	**209**	**100.0**	**10**	**100.0**

The most frequently used medical prevention services acknowledged in both English and Spanish services are shown in the following table:

Table 7

SERVICES RECEIVED	English			Spanish		
	Needed	Received	Percent	Needed	Received	Percent
Hep B Testing	84	46	54.8	5	3	60.0
Hep C Testing Vaccine	101	39	38.6	5	3	60.0
HIV Testing	165	85	51.5	5	3	60.0
HIV Education	159	82	51.6	8	5	62.5
Individual HIV Prevention	126	53	42.1	7	4	57.1
Language Services	81	20	24.7	7	2	28.6
Mental Health Treatment	134	45	33.6	5	2	40.0
Partner Services	69	10	14.5	4	1	25.0
Pharmacy Services	111	42	37.8	7	5	71.4
Prep	94	12	12.8	3	1	33.
Primary Care	140	58	41.4	9	8	88.9
STI Testing	148	64	43.2	4	2	50.
Substance Use Treatment	90	8	8.9	2	0	0.0

Just over half of the English speakers availed themselves of various testing services and HIV education (Hep B testing, 54.8 percent N=46; HIV testing, 51.5 percent N=85 and HIV education 51.6 percent, N=82). Primary care and pharmacy services were the most frequently used services by Spanish-speaking respondents (88.9 percent, N=8, 71.4 percent, N=5), respectively.

BARRIERS TO PREVENTION

Although participants were almost universally satisfied with the quality of prevention services in the agencies they represented, they were in equal numbers certain that the availability of services were inadequate to the needs.

> *"A lot of good work in community as far as prevention and treatment. Prevention side is inadequate. Not reaching population that needs to be reached. Need to do more effective job of prevention and education to bring numbers down."*

They delineated numerous reasons for that, which this section will discuss. Again, the specter of stigma underlies many of the specifics they articulated. As previously mentioned, those at-risk often fear action or even acknowledgment of risk because of how they imagine such recognition would affect their self-definition or how they might be judged by those whom they trust and respect.

> *"Stigma among some ministers and some physicians. They don't believe the numbers probably due to huge trust issues. We need to think of some real innovative ways to deal with this."*

Beyond that, there were systemic issues raised. One was that data about clusters and outbreaks that can be clinically relevant is not readily available to clinicians. This will be discussed in detail in the Response section of the document, but the following quote reflects the opinions of many of the respondents.

> *"We lack sufficient data. Efforts enhanced by better data systems. Timeliness and being more actionable."*

The survey respondents listed very specific barriers that they personally encountered, as shown below. For English speakers, cost of services was the most cited barrier, followed by stigma. For Spanish speakers, stigma was the highest barrier. When considering the barriers, it is helpful to group some of the topics. For example, cost and lack of insurance amplify the crush of financial issues. Stigma and fear of judgment are variations on a theme.

Table 8

BARRIERS TO CARE	English		Spanish	
	#	percent	#	percent
Stigma	40	20.6	3	30.0
Cost Of Services	116	59.8	2	20.0
Did Not Know Where to Go	13	6.7	2	20.0
Fear of Judgment by Provider	25	12.9	0	0.0
Wait Times	32	16.5	0	0.0
Need Night or Weekend Appointments	28	14.4	0	0.0
Too Busy	34	17.5	2	20.0
Uninsured	35	18.0	1	10.0
Total	**194**	**100.0**	**10**	**100.0**

RISK ASSESSMENT

Another key technique for prevention is effective and accurate risk assessment. Respondents were clear that risk assessment must occur 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 risk can be fueled by a panoply of factors. Among these stereotyping, discomfort on the part of clinician or client, and lack of information or misinformation, as seen in the following quote:

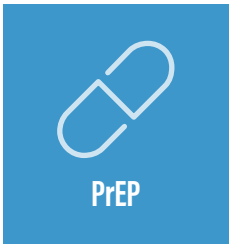
> *"Sometimes you cannot even talk to people about HIV because they think it is something awful. Our community is not educated on this matter. Sometimes people don't even want to mention it. The priority needs to be the education risk of getting HIV treatment, life after diagnosis everything. This condition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

Respondents added that assessment of one's own risk obviously requires information and the courage to move beyond fear of the outcome of testing, as noted repeatedly in this report.

> *"Education is very much needed, especially in the Black Belt area. {But}, even if you present information, not many people actually take heed to the information, or actually will do the necessary steps of getting tested."*

A peer support provider mused about the very disconcerting turn that risk assessment can take for clients and how outreach, especially peer outreach can be the key link to overcoming that:

> *"Sometimes, your body tells you. Sometimes we get people who just can't avoid it because they notice changes in their body and they want to go when it's too late. And sometimes, through outreach, we're able to catch them. In the [Agency], we get people who haven't been tested in years. So, it's just been a mix of both of those for us."*



- INCREASED SCREENING FOR PREP INDICATIONS AMONG HIV-CLIENTS
- INCREASED REFERRAL AND RAPID LINKAGE OF PERSONS WITH INDICATIONS FOR PREP
- INCREASED PREP PRESCRIPTIONS AMONG PERSONS WITH INDICATIONS FOR PREP

The development of PrEP was revolutionary in the prevention of HIV. According to studies reported by the CDC, PrEP "reduces the risk of getting HIV from sex by about 99 percent when taken daily. Among people who inject drugs, PrEP reduces the risk of getting HIV by at least 74 percent when taken daily."

As shown above, the EHE program focuses prevention outcomes 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.

While the strategies and barriers to prevention in general also apply to PrEP, its unique features require strategies specific to it use. Participants determined that the first step in improving PrEP access was to assure that information about PrEP is more widely disseminated to clinicians and individuals. More

importantly, that information should be better crafted to resonate with those who might prescribe it or who might benefit from it. One participant noted that it was estimated that there were at least 11,000 Alabamians with indications for PrEP, but only approximately 600 (5.5 percent) currently taking the medication.

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. One participant suggested that those who care for PWH can be instrumental in this effort.

> *"[Information about PrEP] should be part of HIV positive treatment / education. The healthcare providers need to talk about this and educate the client. It should not be optional to talk about PrEP."*

Well-informed clients are often the first line of encouragement for PrEP use screening in their partners.

> *"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."*

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 in collaboration with communities, have created PrEP information interventions, but they are limited as seen in the following quotes.

> *"ADPH piloted a project where the DIS workers would not only tell people who test neg for HIV about PrEP, but started having them actually link them to PrEP services and f/u to see if they [completed the referral]. However, they were understaffed/underfunded."*

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.

> *"[PrEP is marketed by] word of mouth, marketing, billboards, social media and I tell clients to tell their partners. I don't think it's being pushed a lot to everyone who needs it. Especially among Black women—it's hard to have a conversation with straight Black women about PrEP, because they do not see themselves [in the media about it]."*

Given the PrEP preponderance of financial concerns discussed earlier, the participants also noted additional barriers to access that are exacerbated by some of the public policy related to funding.

> *"I did mention that the Ryan White clinics are in the best position in Alabama to expand PrEP but are limited by not being allowed to use Ryan White money for it, and there is no funding stream for the PrEP support services."*

As this report was being written, the CDC released information about a program that may have a significantly positive impact on enabling more uninsured persons to access PrEP treatment. As part of the *Ready, Set, PrEP* initiative, the Trial Card program is intended to offer PrEP medications at no cost to eligible participants. According to the HHS press release,

> *"Under the contract, TrialCard will verify participant eligibility, enroll eligible individuals, maintain the network of participating pharmacies, distribute the donated medications to uninsured participants, and process requests for the distributed medications. Distribution of the donated PrEP medications was provided by Gilead Sciences Inc. through a short-term contract granted by HHS since September 2019. To qualify for* Ready, Set, PrEP*, people must test negative for HIV, have a valid prescription for the*

medications, and not have prescription drug coverage. All medications are fully covered for qualifying participants; however, the costs of necessary clinic visits and lab tests may vary depending on an individual's income."[15]

Considering the CDC outcomes, participants agreed that Alabama would be better served with a more effective system for wraparound PrEP services. Several discussions from the focus group and interviews centered on the idea that PrEP access needs to be mainstreamed. To affect that, more primary care providers need information about PrEP screening, prescribing, and patient support protocols. They noted that there is not currently an effective referral network nor are there an adequate number of PrEP providers. When asked about the current network and about the percentage of clients who complete referrals and initiate treatment, a participant replied:

"[The referral network is] almost non-existent and not very effective. Patients have to run around trying to find a provider. About half of people with PrEP indications will complete a referral and who initiate treatment is I guess about 10 percent."



- INCREASED KNOWLEDGE ABOUT THE EVIDENCE-BASE OF SSPs
- INCREASE QUALITY OF SSP SERVICES

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

"In Alabama— Focusing on cost benefit from a public health perspective. Show the potential savings to Medicare/Medicaid."

"Legislators are thinking around what their constituents want. Same stigma as when talking about sexual behaviors."

Misinformation about SSP and about the complex factors associated with substance use were cited as significant barriers to adoption of the program. A composite of participant thoughts follow:

"Improper concern that it will give free needles to encourage use. [SSP] It perpetuates drug use."

"For the community in the [rural] area itself, I think there will be a lot of pushback. On every avenue dealing with marginalized communities."

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 better understanding of substance use.

"Stigma reduction. We keep going back in circles to that, but it really is the main idea in these conversations. How can we get people to consider a person who uses a substance to be a sick person just like we would a person who has vision impairment or mobility issues? So, I think it is definitely a good idea. It would be a tool in combating this opioid crisis that we are feeling here in this part of the country."

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.

> *"I think we all have agreed, in our lines of work, among all our colleagues, this is something we need. It's just like actually making it happen; a plan to politically make it legal is what we are lacking."*

Finally, respondents pointed out that an essential benefit of SSP is harm reduction, not just for HIV, but for substance use disorder.

> *"SSP is a public health investment. Each interaction with a medical provider is an opportunity for someone to get the help they need."*



OVERVIEW

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 was part of their routine primary or gynecological care, for example. They reported that many times, it is the client who requests an HIV test and that those requests are sometimes met with clinician skepticism, as discussed in the Risk Assessment section.

As shown in the following chart, the CDC intended outcomes center around opt-out testing, an evidence-based intervention that significantly increases testing and thus, nearly seamlessly addresses stigma, information, and a range of other barriers to diagnosis.

Table-1

CDC CATEGORY	INDICATORS	OUTCOMES
DIAGNOSIS	▪ Knowledge of HIV status ▪ HIV Diagnoses	▪ Increased routine opt-out HIV screening in healthcare and other institutional settings ▪ Increased local availability and accessibility to HIV testing services ▪ Increased HIV screening and re-screening among persons at elevated risk for HIV ▪ Increased knowledge of HIV status ▪ Reduced new HIV infections

OPT-OUT TESTING

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 and thus, somewhat de-stigmatizing and reducing fear of an HIV diagnosis and thus improving testing rates.

> *"[Opt-out testing will] normalize HIV as a chronic illness and not a death sentence. People still think they are going to die. We need to break down the stigma of HIV – especially in Alabama and rural areas and let people know this is not the 80s."*

"Yes, it needs to be routine testing. People are afraid of this testing. I ask myself, why would I get tested, what if I'm positive? I don't want to know. Now, if it's part of routine [opt-out] testing, it is done."

"For me, opt-out testing is really the golden ticket."

Despite the enthusiasm, the opt-out testing is far from standard procedure in Alabama.

"There is, from my experience, very little HIV testing, and almost no routine opt-out testing being done in Alabama hospitals or FQHCs (Federally Qualified Health Centers), or emergency departments (with the exception of UAB). And even less by primary care physicians in private practice."

The participants gave several reasons why this might be the situation. The challenges that some primary care providers face are both organizational and logistical. Logistical concerns include those about the administrative burden that opt-out testing might bring and whether clinics have accurate information about procedures.

"Many physicians don't know Opt-Out testing has been CDC-recommended since 2013. Many barriers are structural. Hospital barriers include payment structure. A lot of hospitals are still using separate informed consent and not standard inclusive opt-out testing consent and they have not updated policies and legal procedures. They do not understand that only very simple documents are required. FQHCs have resistance by providers who think they can figure out who are at risk and they don't understand it's a standard of care. We need a major, statewide systems change."

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, as expressed by a respondent who is a physician:

"Biggest barrier in primary care clinics is discomfort in talking about sexual health. Providers are afraid to sound like they are judging [their patients]. There has to be a normalization of this standard care."

Respondents registered an observation that bridges both the logistical and organizational concerns for healthcare providers and notes that opt-out presupposes access to medical care.

"Opt-out does require that you have a place to go for your regular healthcare, whether that's the Health Department or your regular clinic. It requires those folks to be on board with providing that screening in the first place, that's the challenge I think we have. Our workforce is not prepared to deliver HIV positive status."

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 success of the program.

"Even if people can get tested, the cost of HIV labs for people without insurance [is a problem]. Some people think their insurance company is the one who decides whether they get a free test every year. It's so unclear."

LOCAL AVAILABILITY AND ACCESSIBILITY OF HIV TESTING

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 effect rural parts of the state including:

- Number of sites
- Location of sites
- Transportation
- Actual or perceived costs

Respondents offered that, depending on region, several different venues for testing were available including: CHDs, ASOs, clinics, hospitals, campus health centers, drop-in centers, community medical practices, and CBOs. Despite this, they conceded that needs exceed access.

Combined with the need for increased number and variety of testing sites, respondents emphasized the importance of outreach for informing potential clients of the availability of testing and to facilitate its accessibility.

> *"We've done a lot of outreach at schools and other educational outreach. There's been a major uptick in the last two years with us [agency], where we were for a very long time the initial place that the average gay male would visit to get tested. But we now are seeing a lot of college students and high school students that normally would have gone to the Health Department but learned that they could come to our agency where it was free, and they didn't need an appointment. So, that has brought a whole lot of young people."*

- INCREASED SCREENING OF PERSONS AT ELEVATED HIV RISK
- INCREASED KNOWLEDGE OF HIV STATUS
- REDUCED NEW HIV DIAGNOSES

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. As shown in the following table, most testing was client-initiated (87 percent, N=57 English; 60 percent (N=15) Spanish).

For respondents to the English survey, having unprotected sex with a person whose status was unknown, was the most commonly cited motivation for testing. Testing at a hospital ERs 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 study due to the small sample size.

Table 10

MOTIVATION FOR TESTING	English		Spanish	
	#	percent	#	percent
Unprotected sex with person of unknown status	15	22.7	5	20.0
Unprotected sex with HIV+ person	13	19.7	1	4.0
Tested at ER	2	3.0	6	24.0
Felt sick and did not know cause	10	15.2	4	16.0
Chose to test as part of healthcare	8	12.1	3	12.0
Provider recommended	7	10.6	4	16.0
TOTAL	**66**	**100.0**	**25**	**100.0**

The findings of the survey stress that because the frequency of testing prompted by healthcare provider recommendation is relatively low, opt-out testing could promote knowledge of HIV status. It also suggests that as people are aware of risks, prevention efforts that focus on testing are motivating.



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. Like PrEP, universal access and use of ART are goals yet to be realized. The HRSA outcomes require emphasis on rapid initiation of care and viral suppression by continuing care.

Table 11

CDC CATEGORY	INDICATORS	OUTCOMES
TREATMENT	▪ Linkage to medical care ▪ Viral suppression	▪ Increased rapid linkage to HIV medical care ▪ Increased receipt of HIV medical care among PWH ▪ Increased viral suppression among PWH ▪ Increased early initiation to HIV prevention and treatment for PWH who have disengaged from care

RAPID LINKAGE TO 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 percent (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.

Table 12

NEXT STEPS AFTER DIAGNOSIS	English		Spanish	
	#	percent	#	percent
Appointment with health department or clinic was made	29	43.9	16	69.6
I was told where to get HIV care	33	50.0	12	52.2
Clinical staff or peer went with me to appointment	8	12.1	3	13.0
Total	**66**	**100.0**	**23**	**100.0**

The majority of both sets of respondents engaged in HIV care within 30 days of diagnosis. Of note, 22.7 percent (N=5) of Spanish-speaking respondents did not initiate care for more than 90 days.

Table 13

TIME BETWEEN TESTING AND INITIATION OF CARE	English		Spanish	
	#	percent	#	percent
1-30 days	38	70.4	12	54.5
31-60 days	8	14.8	5	22.7
61-90 days	4	7.4	0	0.0
90+ days	4	7.4	5	22.7
Total	**54**	**100.0**	**22**	**100.0**

Group and interview respondents offered insights about factors associated with timely initiation of care. They emphasized the importance of personalized, multi-faceted support.

> *"[What works in our agency is] follow-up within 48 hrs. with someone who knows them. Personal outreach."*

> *"Getting people in quickly means better retention rates. Trying to give care as quickly as possible, [we provide] peer mentors, navigation, [and encourage] family support, behavioral health. Requires personal outreach, engaging conversations, and tapping into social networks."*

> *"There are a lot of (self-efficacy) barriers. We do a ton for [our clients], more than they might get in primary care offices."*

The financial barriers discussed in each section of this document are relevant in the consideration of both starting and continuing treatment. The next two tables show the insurance status at diagnosis and at the time survey respondents participated in the survey. 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.

Table 14

INSURANCE STATUS	English			
	At Diagnosis		Current	
	#	percent	#	percent
Medicaid	11	16.7	20	29.4
Medicare	5	7.6	26	38.2
Employer Insurance	16	24.2	14	20.6
Other Private	0	0.0	13	19.1
VA	2	3.0	2	2.9
No Insurance	26	39.4	3	4.4
TOTAL (some have multiple sources)	**66**	**100.0**	**68**	**100.0**

The insurance status of Spanish-speaking clients did not improve over the interval between diagnosis and survey completion and even rose. None reported participation in Medicare or Medicaid. The two with "other private insurance" were covered by a partner. During the focus group for Latinx persons, service providers mused about the situation faced by several of their clients. A typical comment follows:

> *"If a client is without legal status. People might feel like they are dying but because they have no insurance they might not seek treatment afraid of receiving a huge bill from the hospital. It's very dangerous. The undocumented people need some sort of medical insurance so they can see the doctor when needed without being scared of a huge bill."*

Table 15

INSURANCE STATUS	Spanish			
	At Diagnosis		Current	
	#	percent	#	percent
Medicaid	0		0	
Medicare	0		0	
Employer Insurance	2	8	1	4.2
Other Private	0		2	8.3
VA	0		0	
No Insurance	18	72.0	22	91.7
Total (some have multiple sources)	25	100	24	100

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 of the focus group 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.

> *"Something like [an HIV diagnosis] does put a strain on the mental health, sometimes, you know, people are like, "I will never find somebody who will love me for me, just because I've got this one thing little thing over my head."*

"I have experienced the ones who will come into the clinic and they're like, 'I want to live and I want to be with my family members. I don't want to have my family members to have to [have to be caregivers for] me at a young age."

"I found that patients were compliant once you addressed the barriers like depression and social issues. I once had a patient who was hiding his meds and sometimes couldn't get back to his hiding place. I had another patient who was being verbally abused and shamed relentlessly for having HIV. The pill was a mark of her shame so it was a struggle for her to take it."

INCREASED RECEIPT OF HIV MEDICAL CARE

To meet the goal of assuring that all PWHs 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 had in discussion about PrEP, that one way to do that would be to deploy community primary care clinician as treatment sites with a proviso:

"Primary care clinics the PrEP discussion is often a very stigmatized conversation when people who are not HIV providers talk to HIV patients. I realized that when I was doing my Fellowship – HIV care is doable by other practitioners if they just take the extra courses. They don't understand it's not as complex as they think."

But even current ASOs and other HIV providers face challenges to offering their clients the range of services that they consider the standard of care. Clinic logistics, availability of reimbursement and funding streams, and adequate staffing are among the challenges.

"[We encounter limits in] staffing, and timing for labs that make it hard to initiate same day care. [We see] 25 new patients per month across all our clinics. Uninsured patients can take a little longer."

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 were able to avail themselves of medical treatment and ancillary services. The following table illustrates their ratings.

Table 16

EASE OF ACCESS (AMONG THOSE WHO USE SERVICES)	English	Spanish
	Easy to Access	
Insurance Assistance	64.4%	36.8%
Case Management	67.3%	44.4%
Dental	64.4%	61.1%
Eligibility Assessment	64.3%	23.5%
Emergency Financial Assistance	64.3%	0.0%
Health Education	72.1%	52.9%
HIV Treatment	80.8%	57.9%
HIV Meds	84.3%	57.9%
Medical Nutrition	62.5%	33.3%
Mental Health Care	64.0%	20.0%
Substance Use Disorder Treatment	64.3%	33.3%

While both groups report that medical treatment and medication were the services that were easiest to obtain, notable disparities between the two groups are very apparent not just in those two services, but in every category.

A member of the Latinx focus group considered this finding and suggested:

> *"People believe that if they don't have social [services] they cannot receive any care. People talk about how medication is very expensive. HIV is not a priority. Most people will just ignore they have any medical problem, HIV included. People don't know that medication can be free. The clinic has the role of educating about resources for medication and care. The clinic must promote itself. People need to know that they speak Spanish."*

In addition to these, greater utilization of care demands an understanding of the barriers that intensify health disparities in care.

> *"Bigger barriers that clients face are a problem in accessing care. [These include] transportation-substance use disorder, severe mental health problems"*

> *"[Barriers] range from individual level, social and structural determinants of health, stigma, disclosure, coping, resilience, interpersonal, lack of social support. Cultural competence of clinics, systemic racism, policy level- lack of health insurance and no Medicaid expansion. Lots of barriers at multiple levels."*

Another consideration is the overall health status of clients beyond their HIV diagnosis. As can be seen in the next table, 52 percent (N=35 English) and 33.3 percent (N=8 Spanish) of the survey respondents present with comorbidities. As with many Alabamians, the two most found conditions are diabetes and hypertension. It is worth noting that the clinicians who treat these conditions in HIV clients, may also serve as ancillary or primary providers of HIV care, thus expanding access to HIV care.

Table 17

HEALTH CONDITIONS	English		Spanish	
	#	percent	#	percent
Diabetes	15	22.1	1	4.2
Hypertension	30	44.1	3	12.5
Mental health disorder	8	11.8	0	0.0
Substance use disorder	3	4.4	0	0.0
Any other health condition	36	52.9	8	33.3
Total	**68**	**100.0**	**12**	**100.0**

In summary, the respondents to groups, interviews, and surveys listed the most essential barriers to HIV treatment, as have been suggested or directly mentioned in this report.

Table 18

SUMMARY OF BARRIERS TO CARE	
Client	**Systemic**
Fear of HIV status disclosure	Misunderstanding of culturally appropriate care
Financial issues	Need for accurate, timely information
Lack of social support	Resources to deliver personalized care
Misinformation	Social determinants of health
Psychosocial factors	Systemic causes of health disparities
Stigma	
Transportation	

INCREASED VIRAL SUPPRESSION

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 patients whom they were able to reach.

"[We have] pretty high rates [of ART compliance]. Overwhelming majority achieve viral control within 8 months—85 percent plus."

The barriers to ART are the same ones previously encountered as are most of the facilitating factors. The respondents were direct and clear as the following quotes show.

"Engagement and close contact. If we had some way to provide phones to patients- that has become apparent during this pandemic. Touching base with clients between regular appointments also helps."

"[Access to ART] has gotten better with one pill once/day, and fewer side effects. [The other thing that helps adherence is] trust in the providers—patients won't take meds without that trust. If they can continue to access care. Evaluation of the other barriers usual suspects- family support, peer support, etc."

"[Clinicians need to assure that their patients are] taking medicine, that they have self-efficacy. We need to make sure they are adherent and make sure they get refills in a timely manner. [We need to foster] patient engagement. Showing you care about their lives, empathy, and good discussion."

REENGAGEMENT FOR OUT OF CARE

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." The barriers to maintaining care are those covered earlier. as the respondents summarized.

"[Patients suspend care due to] Competing demands, life stressors, lost job or relationships. There are patterns to continue or suspend care."

"[Clients encounter] lots of reasons, financial, housing, transportation, incarceration, mental health, substance abuse and lack of social support."

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 that is gathered from these contacts not only assist the clients who are reached, but build the data needed to determine best practices.

"Outreach workers try to contact by letter and phone, make home visits to high risk (pregnant, etc.) trying to improve using data to keep people in care."

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 personally 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.

"When they go to someone's house to check up on them. When I call the patients we tend to get more call-backs. Provide transportation and some incentives like food boxes."

"If a person hasn't been seen or hasn't been communicating, we reach out and try to find them. Nine times out of ten, this is what has happened: They've fallen off their regimen. They're not taking their medication, or whatever. We try to encourage them back in. There has only been, in my—and I've been around a long time, there has only been one time that a person has fallen out and we didn't get them back in care so, it's just continuing communication with them."

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.

"[We track] no show rates and those who are not virally suppressed because something isn't working for them. Unstable housing. We screen for other issues."

"The sooner you can act the better, people disappear after a period of time and we can't reach them by phone and their living arrangements change."

The importance of statewide and ADPH facilitated tracking were also discussed as critical to improving the efficiency and efficacy methods for keeping clients engaged.

"[We need] better use of data for care, better coordination on statewide level. Data process where once per quarter we send in a list to state health department and they check for recent viral loads, death, or incarceration reports, try to match the data, and send report back to shorten our list. We need more data collaboration! This is not quite operational everywhere yet."

Supporting the findings from the interviews, 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 to maintaining care. Access to medications and the need to meet with clinicians to continue prescriptions, may also contribute to maintaining care.

Table 19

VALUE OF SERVICES	English		Spanish	
	#	percent	#	percent
Assistance With Health Insurance	29	43.9	10	40.0
Case Management	38	57.6	11	44.0
Dental Care	33	50.0	12	48.0
Eligibility Services	32	48.5	7	28.0
Health Education	33	50.0	8	32.0
HIV Medical Care	45	68.2	13	52.0
HIV Medication	41	62.1	14	56.0
Medical Nutrition	17	25.8	8	32.0
Mental Health Care	14	21.2	3	12.0
Substance Use Treatment	2	3.0	0	0.0
Total	**66**	**100.0**	**25**	**100.0**



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 improvement of surveillance and response to HIV clusters. As shown in the table below, those policies must more rapidly identify clusters in real-time and have the infrastructure in place to more effectively contain them.

Table 20

EHE CATEGORY	INDICATORS	OUTCOMES
RESPONSE	▪ Public policies to support each of the indicators	▪ Increased health department and community engagement for cluster detection and response ▪ Improved surveillance data for real-time cluster detection and response ▪ Improved policies and funding mechanisms to respond and contain HIV clusters and outbreaks ▪ Improved response to HIV transmission and cluster outbreaks

✚ INCREASED HEALTH DEPARTMENT AND COMMUNITY ENGAGEMENT FOR CLUSTER DETECTION AND RESPONSE

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.

An EHE Planning Group (EPG) was convened and continues to meet monthly via Zoom to evaluate current practices and policies related to each of the CDC outcomes, suggest alternatives, and revisions. Their input and the findings of this needs assessment will continue to inform the development of the strategic plan. Following its completion, the EPG will be involved in the implementation and ongoing evaluation of proposed strategies.

- IMPROVED SURVEILLANCE FOR REAL-TIME CLUSTER DETECTION AND RESPONSE
- IMPROVED RESPONSE TO HIV TRANSMISSION AND CLUSTER OUTBREAKS

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 a variety of data points, such as testing results, as the following quote reveals.

> *"Not knowing about clusters [is a problem]. Negative tests are not reported, only positives. So, we don't know difference between no cases and no testing in rural communities or anywhere else. We don't know where testing is not happening. Not having real time data from the ADPH because their data is a year or so behind. Unless we do the testing, we can't share data because of HIPAA. If the state does testing, they can refer to us. Without consent, we can't follow up. Huge issues with having and sharing data to follow clusters and to intervene."*

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.

> *"Our data on HIV infections probably has a year lag, but you can find out more directly from them. There is not currently a way to share information about patients who are out of care from ADPH to ASOs, unless they are already the ASOs patients."*

> *"Statewide data coordination [is needed]. Don't even know how many people are on PrEP on a statewide level. Need real-time community level data, and [we need] more rapid data. ADPH shows where infections were a year ago and we need to know about last week. ADPH needs a way to coordinate data so we can link patients' info. HIPAA compliance rules don't allow robust, rapid coordinated data. Need good data design and infrastructure and funding, shooting in the dark without it."*

- IMPROVED POLICIES AND FUNDING MECHANISMS TO RESPOND AND CONTAIN OUTBREAKS

Respondents offered numerous policy suggestions specifically related to treatment and testing, as seen in several sections of this document. When contemplating more general public policy, they tended to keep to the topic of data systems and the impact that improvements would have on their clinical efforts.

> *"Increased funding for testing so we can test more. Also decrease barriers with insurance companies. Funding the ASOs to respond to their unique barriers. Transportation for rural areas."*

> *"We need data systems and analytic capacity in-house for rapid response. Data systems are really inadequate. Funding needs to focus on data-driven approaches [to treatment and care]. Need to update our data systems to have data in real time.*

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 of the sections, but warranted review beyond those targeted discussion. These Special topics include:

- MOLECULAR HIV SURVEILLANCE
- UNIQUE CHALLENGES FACED BY LATINX PEOPLE
- UNIQUE CHALLENGES FACED BY PEOPLE WITH TRANSGENDER EXPERIENCE

CONSIDERATION OF MOLECULAR HIV SURVEILLANCE

During the discussion of Response at one of the EPG 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 as comprehensive a reflection of community issues as possible, a focus group was scheduled to elicit participant thoughts on the 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 in 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 has been inadequate transparency of how data might be used.

> *"For me, I am not a proponent of molecular surveillance because it gets to be a little tricky in terms of who uses and utilizes the data and for what purposes. Oftentimes, there's no disclosure as to how the data is being utilized for interventions. So, I'm a little skeptical."*
>
> *"I think that, in work with consumers, what often generates that sense of distrust is when there's not a whole lot of transparency of what the data is going to be used for. I think there's a benefit when research [is reported] back and explains how that data was used and how, hopefully, preferential outcomes happen because of the use of that data."*

The concerns were reported to be a concern for transgender persons. 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.

> *"So, I don't think that what we are trying to gain from molecular, from a Transgender perspective, is going to benefit that vulnerable community. Their level of engagement has never been great; and then you bring in molecular and what we feel in the Trans community [is that] we're laboratory rats with red eyes, and there's still no benefit or outcomes to the data that you're collecting."*

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
- Community involvement in the development and implementation of policies related to molecular surveillance

> *"There's an education component to it to educate the community. The reason why data is important; the reason why showing up and making your voice counted, I think it all goes back to the messaging, but the positive is, there is a tool that the community can understand and also take leadership."*

CHALLENGES FACED BY LATINX PEOPLE

Conversations with focus group and interview participants broached the unique obstacles to receiving care that have been encountered by the Latinx community. To better understand the experience of Latinx Alabamians seeking care, both surveys were also available in Spanish and a focus was conducted in Spanish for clients and providers. The findings of the surveys are shown in the body of this report and in the appendices. The insights that were gleaned from the groups and interviews are presented here.

Table 18 delineated several of the individual and systemic barriers that PWH and those at-risk might come up against. All of these were relevant to Latinx individuals, as were the overarching themes presented earlier, according to participants. As would be expected, anti-immigrant public policies and political rhetoric can be, at the very least, inhibiting to Spanish-speakers seeking care.

> *"I believe [access to services] is a very serious [concern] because we live in a state where immigrants are criminalized just because they are immigrants. [Their status as] immigrants, legal or undocumented, will come into consideration when they request services. The assistance is based on whether or not they have papers. There is a lot of stigma [from this] and it affects our families."*

The report repeatedly mentions the need for information and the challenges of misinformation 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.

> *"I have talked to other people about this condition, they are supposedly my friends, but they say people with this condition are disgusting. Sometimes I have to hold myself to say things to avoid the problem. I know that if they learn that I have this condition they will not be my friends anymore."*

> *"The problem might come from the patients who are not getting treatment and don't have enough information about the condition maybe because of language barriers and lack of translation services. The resources are not always available in the needed language, so people will not receive the service needed and therefore they will not be referred to where they might need to go."*

Any of the barriers that might be present, whether language differences, misinformation, cultural misunderstanding or resource limitation can have an impact on specifics of care and prevention. When asked about barriers to testing, respondents offered the following observations:

> *"People are afraid of this testing. I ask myself, why would I get tested, what if I'm positive? I don't want to know. Now, if it's opt-out, a part of the routine, then testing is done and taken care of."*

> *"Another barrier is distance and transportation. I believe there is a need for other clinics/testing sites more available to the community. Also, maybe the times are a problem. We know that our community works* very hard and sometimes people need to miss work to go to the clinic for testing or treatment. The priority is work so people skip treatment because they need to go to work. Maybe to be closer to the community there might be a weekend time for testing and treatment."

> *"It should not matter [what] your ethnicity [is]. If you need to get tested, you need to get tested. People get detected for different reasons. In my case, they performed various testing [in preparation for] surgery. All this is important because nobody told me I was HIV positive because of the language barrier. They told other people instead that they were supposed to support me."*

Personal risk assessment is enhanced by culturally-directed information and participants offered several strategies for improving access. They indicated that "public events," like health fairs are useful, especially if HIV-related information in embedded in an event geared to several health topics. Once again, the need for normalizing risk assessment and testing was mentioned.

"It's all about education and promotion. People need to learn that this [HIV test] is a test like any other, like diabetes. You have diabetes or not, you have cholesterol or cancer."

Respondents were also queried about how the members of their community learn about HIV in order 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.

"Our culture is afraid to learn about this condition. What we need is support to participate and learn about doctors, to learn that HIV is not a death sentence and for that we need a lot of education."

Respondents had several suggestions about how to overcome testing obstacles. They stressed that Latinx persons who present for care, need be met by someone to whom they can relate to in language and hopefully in culture. Peer mentors appear to be key.

"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."

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.

"Partner communication is very important. When you have a partner, you need to talk about this. We [tell them that we] have this medication as an option to have fulfilled life even with this condition."

"The HIV positive partner needs to disclose [their status] and educate their partner. My partner is negative, but we always talk about everything and I explained my status. It's a personal decision to take the medication or not. HIV positive people need to tell sexual partners about their conditions. [When we do that] we do not fail in our responsibility to disclose and help everyone make an educated decision."

Participants were asked about the experience of Latinx people whom they know, when they seek treatment. Again, they spoke of the confluence of barriers, so often worsened by immigration status. They were clear that HIV care does not occur in a vacuum and that clients might present with other health conditions that they may not have resources to address.

"There is a huge need for mental health, legal assistance, immigration services and we really need more funds to educate and really help our community."

"We have so many issues with lack of funding for people without legal documentation. Ryan White will not cover for example a needed colonoscopy. Eye care for example we need to make sure to have no bills for this type of care. When you can't afford this service you just can't get it. I believe that the message needs to be that we need more resources to have comprehensive care. Ryan White will not cover hospital stays when you don't have legal documentation. There are clients with thousands of dollars on hospital bills, so people stop going to take specialty care."

"People might feel like they are dying but because they have no insurance they might not seek treatment afraid of receiving a huge bill from the hospital. It's very dangerous. The undocumented people need some sort of medical insurance so they can see the doctor when needed without being scared of a huge bill."

The following table summarizes the HIV-related prevention and treatment needs for the Spanish-speaking community.

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 people who are transgender identified, the team was unable to sufficiently recruit potential respondents to complete the survey. With the assistance of EPG, a group of transgender women agreed to participate in a focus group to discuss their experiences in attempting to secure 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, may be underinsured or uninsured, for example. Several other themes were posited and affirmed by the participants when considering their healthcare:

- Gender-affirming care
- Representation of trans-identified persons in staff and messaging
- Holistic care, that includes gender awareness in all phases of wellness and medical/treatment care
- Stigma
- Individualization vs stereotyping
- Client priorities
- Impact of hormone treatment on HIV prevention and care
- Maintaining treatment
- 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 practices such as assuring use only of 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 often, it falls on them to ask for that care and to educate providers on how to deliver it.

"When they [providers] find out that [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."

"I am uncomfortable going [for medical care]. Seeing someone they are not used to seeing makes them uncomfortable. [I do not like] questions about menstrual cycles. We [transgender women] are way past that."

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, as seen in the following quotes.

"[Representation is the] visibility of someone who looks like you. It is comforting. Representation is an intentional service."

"[We need to] have someone who reflects you on the staff. Representation is affirming."

"Hard to find someone who I could identify with at some level. I came across one who is experienced in treating trans-people. Find someone you can identify with at some level."

Gender-affirming care further assumes that clients are 3-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.

"Finding a doctor who can give you the things that you need, i.e., hormone treatment [is hard]. There are just 2 in Birmingham. Gender care services are rare."

"The healthcare for transwomen in [my home state] is great, but not here. I found myself going back home when it was time for hormone treatment. There are no places for referrals here."

"We need holistic care, not just transgender care."

The absence of gender-affirming care can have dire consequences for trans-identified women:

"I want to make sure that we have what we need here. They just do not feel affirmed and so they do illegal silicone and black-market hormones."

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 many times, they define their healthcare in that context. That they were also transwomen of color enhanced the likelihood of being stigmatized.

"[We encounter stigma in medical care]. I don't want to be judged anymore, I am already trans and Black. We already have enough on our backs."

Where the respondents were most adamant was 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, who have 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.

"We are not all the same. We are not going to want the same things. I do not want to be a statistic. We should be treated as equals. We are individuals and not a group."

"I am not knocking sex workers, but that is not all of us. Some of us are married. We are not just sexual."

"There are transwomen who are educated and are capable, I am so much more than that. When I walk into a room you will respect me. We can come from people who are not just street smart, but book smart. We are walking the walk to be great."

Building on those perceptions, participants said that they needed more healthcare and mental healthcare providers who would elicit health goals from them and create prevention and treatment plans based on those goals. They related numerous experiences where HIV client education and prevention messaging seemed geared more to MSM than to them. They also cautioned that providers should not make assumptions about their transition status without confirmation of it.

"Most programs are designed to assume that gay men and transwomen are in the same place. They were designed to assume that all transwomen are sex workers. The program created for transwomen in Alabama are not designed to help us grow. Programming needs to move us out of the shadows and moving forward then they will come out of the shadows."

"They throw condoms at us, but there is no messaging behind it. We have been tokenized and they still misgender me and give me information for men who have sex with men and that is not me."

"Syringe services never consider the use of syringes by transwomen using injections for hormone therapy."

"Those who are promoting insertive condoms are not doing a good job for transwomen. It is offensive how it is explained. No questioning about vaginal construction [or stage of transition]. [We need] inclusive language and respectful understanding of the client's situation."

"Trans-identified women need sex education that is for them."

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.

"We need to get more people on PrEP.. It needs more presentation and education targeted to transwomen. We need health navigators who are transgender identified. We need to get services to sex workers."

"[PrEP and prevention providers need to] make sure that [they have transwomen who can meet transwomen where they are. When I moved here, I was met with resistance from the gatekeeper and needed to earn their trust. We have to earn trust by being in the front line like in the clubs before we can do real prevention. Let them know they have a sister."

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. Further,

the CDC recommends that those who use both PrEP and hormone therapy (HT) "see their healthcare providers every three months for monitoring and follow up."10

Those participants who were skeptical about PrEP, believed that they are not being given adequate or accurate information about PrEP, as well as ART and HT 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. One participant was notably suspicious about the reason that she was prescribed PrEP.

> *"Communities are rejecting PrEP because they are not being informed adequately and honestly and the number of users is dropping."*

> *"PrEP can affect our hormone therapy and here [in Alabama] they [providers] put you on PrEP just for the numbers and then the grant money keeps coming. It is not even explained in an inclusive way and does not consider how else it might affect us."*

> *"They just need to be honest with the risk of side effects, especially with respect to hormone therapy."*

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 there were practices or policies that 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 that they believe they are being heard by their clinicians.

> *"It is almost impossible to keep them in care. It's all about a mental thing. Money is a problem and also worries about how it affects hormone therapy."*

> *"We need a protocol that combines hormone and HIV medications. They want to be the women who they imagine themselves to be. The healthcare for transwomen is not great here. I found myself going back home when it was time for hormone treatment."*

> *"We don't want to be micromanaged about medication. Anti-retroviral therapy is not as important as hormone therapy to most transwomen. Transwomen have the belief that people won't help or can't help us."*

> *"[I want my doctors to address] the logistics of not just my transition, but my overall health. Hormone therapy affects other organs. We need mental healthcare too."*

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.

These points are reinforced by information reported by the National AIDS Housing Coalition (NAHC):[9]

- Effectively addressing HIV risk and health care disparities requires attention to structural factors - environmental or contextual factors that influence health
- Housing affects an individual's ability to avoid exposure to HIV; an HIV-positive individual's ability to avoid exposing others to HIV; and the ability to access and adhere to care
- A large body of evidence now proves that housing interventions are an essential and cost-effective component of HIV prevention and health care for homeless or unstably housed persons with HIV/AIDS (PWH)
- HIV prevention and care strategies will not succeed without addressing structural barriers such as homelessness and housing instability
- Housing status is likely the most important characteristic of the PWH who seeks services—the most significant determinant of PWH health and risk outcomes[10]

To further support these assertions, NAHC cites research findings about the extent to which homelessness poses a profound risk factor for HIV infection:

- Rates of HIV infection are 3 times to 16 times higher among persons who are homeless or unstably housed, compared to similar persons with stable housing
- 3 percent to 14 percent of all homeless persons are HIV positive (ten times the rate in the general populations
- 70 percent of all PWH report a lifetime experience of homelessness or housing instability
- Over time studies show that among persons at high risk for HIV infection due to injection drug use or risky sex, those without a stable home are more likely than others to become infected.

While these are national statistics, the situation in Alabama is at least as alarming. According to the Institute for Human Rights, as of 2018, 800,000 Alabamians lived in poverty and 3,434 experience homeless on any given night.[11] Both Montgomery and Birmingham have been among the top 20 cities in the US reporting the highest rates of sexually-transmitted infections including HIV.[12]

This study questioned survey participants about their housing status. Previous discussions in this document have shown the rates of poverty and financial insecurity among respondents. As the next table

reveals, in this sample 17.7 percent (n=57) of the entire sample (clients and community members) believe that they are unstably housed or homeless.

Table 21

HOUSING STABILITY	Frequency	Percent
Very stable	134	41.6
Stable	131	40.7
Neutral	43	13.4
Unstable	8	2.5
Very Unstable	6	1.9
Total	**322**	**100**

The next table delineates the housing status of participants. Of those who are housing insecure, 84.4 percent (n=38) were living temporarily with friends or family and 8.9 percent (n=4) were homeless. Of the entire set, these respondents represented 11.5 percent and 1.2 percent, respectively.

Table 22

HOUSING STATUS	Frequency	Percent (all respondent groups)	Percent (those with housing insecurity)
Own a House	103	31.2	
Rent an Apartment or House	146	44.2	
Living Permanently with a Friend Or Family	36	10.9	
Living Temporarily with a Friend Or Family	38	11.5	84.4
Temporary or Transitional Housing	2	0.6	4.4
Treatment Program	1	0.3	2.2
Homeless	4	1.2	8.9
Total	**330**	**100**	**100**

Participants in the interviews and focus groups shared insights that support the NAHC findings and added context to the numbers that are found in the respondent tables. In every facet of HIV prevention, treatment and care, the significance of housing security influenced the outcomes of their clients.

"People are dealing with homelessness... so, going to their regular checkups is not a priority when you don't have a house to live in."

"[We] need to make sure that the basic needs are met before we can ask folks to make a huge commitment to changing their lifestyles. That could include transportation or housing assistance."

"Unstable housing [predicts who might disengage from medical care]".

"It is going to take a lot of hard work, and sometimes that does mean making sure that people have a house to live in and helping them get those services. But for some people, that is legitimately their biggest barrier. They don't have shelter. They don't have a place to keep their medicine."

Respondents identified many of the specific problems that people who are marginally housed or experiencing homelessness encounter related to prevention. Yet again, stigma reigns as a primary barrier. The burden of stigma is multiplied in this group of clients. Stigma attached to homelessness can include misrepresentation of how people become homeless.

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 mental illness, physical disability, history of incarceration, systemic racism, and other discriminatory ideologies are embedded with their own widespread stigmatizing attributions. As has been discussed throughout this document, the risk of encountering stigma inhibits persons from seeking care.

> *"Homeless persons [we see] went to Pensacola for treatment because of fear of someone knowing that they were coming to us [for HIV treatment]."*

> *"Clients do not to disclose, don't want care, don't want to be seen in our facilities"*

> *"They don't know that there are medications that can make them undetectable, so they do not have to live with the stigma of people being afraid to be around them."*

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.

> *"We serve homeless women with children. Clients have engaged in sex work to get money for diapers and formula for babies."*

> *"Sex workers have their own business in the street and are concerned about being found with meds."*

Insecure housing can lead to exacerbation of 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.

> *"I can't imagine getting these results, and I don't have somebody I can talk to, or somebody to help me navigate being newly diagnosed. Even on down the line, because we don't know what this is doing to a person's mental health."*

> *"Our clients face bigger barriers to prevention and treatment. [They include] lack of transportation, substance use disorder and severe mental health problems."*

A difficulty that those who are experiencing homelessness face is a lack of typically recognized forms of identification, such as a driver's license or government-issued identification card. No identification means reduced access to services, no ability to enter into a lease or even find a room to rent.

> *"ID a problem. We provide housing for 2 years and make sure people have valid ID [so that they can] get other services."*

> *"ID is an issue, they don't have proper ID and they have no credit or credit history."*

While a history of incarceration is an established possible precursor for homelessness, an often-overlooked risk is the fear of incarceration because of outstanding warrants. With this awareness, homeless services

providers sometime include in events for their clients, legal services that can lead to dismissal of charges and expunging of records.

> *"With no address, people think that they cannot be served. [Agency holds events that have] huge turnout. [We have] lawyers and justice system representatives who attend and waive fees so that [clients] can get identification cards and have their records expunged so they will not be arrested."*

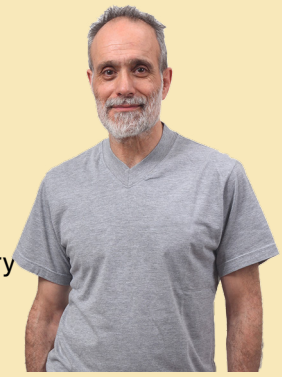
Several respondents noted that clients in homeless services organizations and shelters could be better served if they had access to HIV-related information, testing, prevention, and treatment care. Though some HIV-service agencies offer such care in those organizations, those who do not noted the advantage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

> *"We have several homeless shelter organizations and I feel like HIV testing and education should be there."*

> *"People on the street do not know what services are available to them. We have housing, transportation, and medical care access for them. We need to help them find out about the services."*

SUMMARY OF NEEDS FOR CLIENTS 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 for people experiencing homelessness, to reduce stigma and support HIV status disclosure



CONCLUSION

For purposes of this report, the resources that Alabamians provide and the obstacles that they face in securing and maintaining HIV prevention and treatment were segmented by the topics delineated by the CDC. As was shown, however, several central themes overarch these efforts.

Respondents noted the importance of widely disseminated, accurate information about sexuality in general and HIV prevention and treatment. They emphasized the importance of access to clinicians who were competent and compassionate and with whom they could trust with their most intimate narratives and peer providers with whom they could identify. They were profoundly grateful when these were available. Respondents in all aspects of the study noted the progress that Alabama has made, but also outlined the path that would lead to critical improvements in the continuum of prevention and care.

Regardless of how they self-identified, participants acknowledged being challenged by stigma that they experienced in all components of HIV prevention and care access. At times, they felt disparaged for their very identities. They stressed the importance that systems of care should be alert to stigmatizing practices and attitudes and repeatedly asserted that representation from marginalized groups in systems of care could help overcome these.

At least in this sample of respondents, adherence to prevention practices and treatment protocols were considered important, but success was often hampered by access to services, insurance challenges, competition between funding basic needs and medical care, and less than optimal information that would support accurate risk assessment and motivation to initiate or maintain care.

Respondents with special needs, such as Latinx persons and people with transgender experiences, affirmed that their communities provided them with unique resources and they spoke of the support that they garnered each other. With equal clarity, they articulated that unfortunately, they can encounter unique challenges when seeking HIV prevention and treatment.

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 not only by this report, but 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.

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10. This presentation was provided by AIDS Alabama offers several housing options for people living with HIV/AIDS and their families as well as people who are homeless regardless of their HIV status.

11. https://sites.uab.edu/humanrights/2020/06/09/std-rates-among-the-poor-and-homeless-in-alabama/

12. ibid

ACKNOWLEDGEMENTS

This report could not have included the range of perspectives and depth of insight that it does without the generous and courageous responses of those who participated in the surveys, interviews, focus groups, and the EPG.

In the middle of the COVID-19 pandemic, one of the most disruptive public health emergencies in over a century, people rallied to assure that as many voices as possible could be heard. Furthermore, those who did participate were notably candid and comprehensive in their representation of their experiences and that of the people for whom they spoke.

The EPG members have attended monthly planning meetings and reviewed methods, findings, and strategies. They sought creative ways to recruit participants and encouraged as broad a sample as was possible.

To all involved, Alabama Partners for Health, Inc. extend our deepest appreciation for the honor to hear and share your narratives.

APPENDIX 1: DEMOGRAPHICS OF RESPONDENTS TO THE ENDING THE HIV EPIDEMIC SURVEY

The following charts illustrate the demographics characteristics of the respondents to the Ending the HIV Epidemic Survey.

Appendix 1: Table 1 - Age of Respondents

AGE	English	Spanish
Average	49	40
Youngest	26	25
Oldest	81	58

Appendix 1: Table 2 - Sex of Respondents at birth and currently (English)

ENGLISH	Assigned Sex at Birth		Current	
	#	percent	#	percent
Male	43	67.2	43	65.2
Female	21	32.8	32	48.5
Total	**64**	**100.0**	**66**	**100.0**

Appendix 1: Table 3-Sex of Respondents at birth and currently (Spanish)

SPANISH	Assigned Sex at Birth		Current	
	#	percent	#	percent
Male	17	70.8	16	66.7
Female	7	29.2	8	33.3
Total	**24**	**100.0**	**24**	**100.0**

Appendix 1: Table 4-Sexual Orientation

SEXUAL ORIENTATION	English		Spanish	
	#	percent	#	percent
Bi-Sexual	3	4.6	0	
Gay/Homosexual	25	38.5	5	21.7
Heterosexual	35	53.8	18	78.3
Queer	1	1.5	0	
Asexual	1	1.5	0	
Total	**65**	**100.0**	**23**	**100.0**

Appendix 1: Table 5 -Relationship Status

RELATIONSHIP STATUS	English		Spanish	
	#	percent	#	percent
Single	42	61.8	8	33.3
Single With Family	0	0.0	1	4.2
Married	11	16.2	8	33.3
Partnered	11	16.2	6	25.0
Divorced	4	5.9	1	4.2
Total	**68**	**100.0**	**24**	**100.0**

Appendix 1: Table 6-Education

EDUCATION	English		Spanish	
	#	percent	#	percent
< High School (HS)	3	4.5	6	26.1
HS	21	31.8	9	39.1
Some Tech	0	0.0	1	4.3
Some College	17	25.8	0	0.0
Tech	3	4.5	5	21.7
College	12	18.2	1	4.3
Some Post-Grad	5	7.6	0	0.0
Graduate	5	7.6	1	4.3
Total	**66**	**100.0**	**23**	**100.0**

Appendix 1: Table 7-Income Sources

INCOME SOURCE	English		Spanish	
	#	percent	#	percent
Full-Time Employment	26	39.4	10	41.7
Part-Time Employment	9	13.6	6	25.0
Occasional Work	11	16.7	5	20.8
Income From Partner	1	1.5	1	4.2
Income From Other Family	1	1.5	1	4.2
Social Security Disability Insurance (SSDI)	20	30.3	0	
Social Security Insurance (SSI)	11	16.7	0	
School Financial Aid	1	1.5	0	
Retirement	2	3.0	0	
Total	**66**	**100.0**	**24**	

APPENDIX 2: DEMOGRAPHICS OF RESPONDENTS TO THE ALABAMA HEALTH NEEDS ASSESSMENT SURVEY

Appendix 2: Table 1-Age of Respondents

AGE	English	Spanish
AVERAGE	39.8	44.5
YOUNGEST	17	36
OLDEST	72	57

Appendix 2: Table 2-Sex of Respondents at birth and currently (English)

ENGLISH	Assigned Sex at Birth		Current	
	#	percent	#	percent
Male	80	34.8	80	34.6
Female	150	65.2	149	64.5
Queer	0	0.0	2	0.9
Total	**230**	**100.0**	**231**	**100.0**

Appendix 2: Table 3-Sex of Respondents at birth and currently (Spanish)

SPANISH	Assigned Sex at Birth		CURRENT	
	#	percent	#	percent
Male	4	40.0	5	50.0
Female	6	60.0	5	50.0
Total	**10**	**100.0**	**10**	**100.0**

Appendix 2: Table 4-Sexual Orientation

SEXUAL ORIENTATION	English		Spanish	
	#	percent	#	percent
Bi-Sexual	20	8.8	1	10.0
Gay/Homosexual	34	14.9	0	
Fluid	1	0.4	0	
Heterosexual	162	71.1	8	80.0
Lesbian	6	2.6	1	10.0
Pansexual	2	0.9	0	
Queer	3	1.3	0	
Total	**228**	**100.0**	**10**	**100.0**

Appendix 2: Table 5-Relationship Status

RELATIONSHIP STATUS	English		Spanish	
	#	percent	#	percent
Single	124	55.6	1	10.0
Married	47	21.1	7	70.0
Partnered	36	16.1	2	20.0
Divorced	12	5.4	0	
Single With Family	2	0.9	0	
Friend/Roommate	1	0.4	0	
Widowed	1	0.4	0	
Total	**223**	**100.0**	**10**	**100.0**

Appendix 2: Table 6-Education

EDUCATION	English		Spanish	
	#	percent	#	percent
< HS	7	3.0	0	
HS	38	16.5	1	10.0
Some Tech	6	2.6	1	10.0
Some College	79	34.3	1	10.0
Tech	8	3.5	0	
College	37	16.1	2	20.0
Some Post-Grad	20	8.7	0	
Graduate	35	15.2	5	50.0
Total	**230**	**100.0**	**10**	**100.0**

Appendix 2: Table 7-Income Sources

INCOME SOURCE	English		Spanish	
	#	percent	#	percent
Full-Time Employment	111	48.1	7	70.0
Part-Time Employment	167	72.3	2	20.0
Occasional Work	37	16.0	0	
Income From Partner	10	4.3	1	10.0
Income From Other Family	36	15.6	0	
SSDI	17	7.4	0	
SSI	19	8.2	0	
School Financial Aid	29	12.6	0	
Retirement	3	1.3	0	
Total (some have multiple sources)	231	100.0	10	100.0

Appendix 2: Table 8 -Insurance Status

INSURANCE	English		Spanish	
	#	percent	#	percent
Medicaid	44	19.0	0	
Medicare	29	12.6	0	
Employer Insurance	101	43.7	6	60.0
Other Private	28	12.1	0	
Veterans Administration (VA)	5	2.2	3	30.0
ACA	5	2.2	1	10.0
No Insurance	25	10.8	1	10.0
Total (some have multiple sources)	**231**	**100.0**	**10**	**100.0**

APPENDIX 3: LINKS TO SURVEYS

The surveys used in this needs assessment can be found at the following links:

- Ending the HIV Epidemic Project Survey (Client survey)
- https://www.surveymonkey.com/r/ADPH_Client
- Alabama Health Needs Assessment Survey (Community survey)
- https://www.surveymonkey.com/r/ADPH_Community