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:

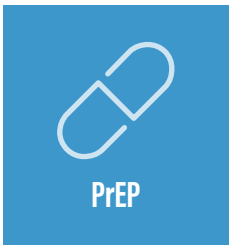
- Reduce stigmatizing.
- Improve access to accurate, culturally-appropriate, timely information about sexual health information and HIV.
- Increase the resource base for public health, agencies and individuals.
- Culturally-appropriate care.

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.