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Houston Area Comprehensive HIV Prevention and Care Services Plan 2017 - 2021

*Capturing the community's vision for an ideal system of
HIV prevention and care for the Houston Area*

HOUSTON EMA HIV CARE CONTINUUM

What is the Care Continuum?

The HIV Care Continuum, previously known as a Treatment Cascade, was first released in 2012 by the Centers for Disease Control and Prevention (CDC). It represents the sequential stages of HIV care, from being diagnosed with HIV to suppressing the HIV virus through treatment. Ideally, the Care Continuum describes a seamless system of HIV prevention and care services, in which people living with HIV (PLWH) receive the full benefit of HIV treatment by being diagnosed, linked to care, retained in care, and taking HIV medications as prescribed to achieve viral suppression.

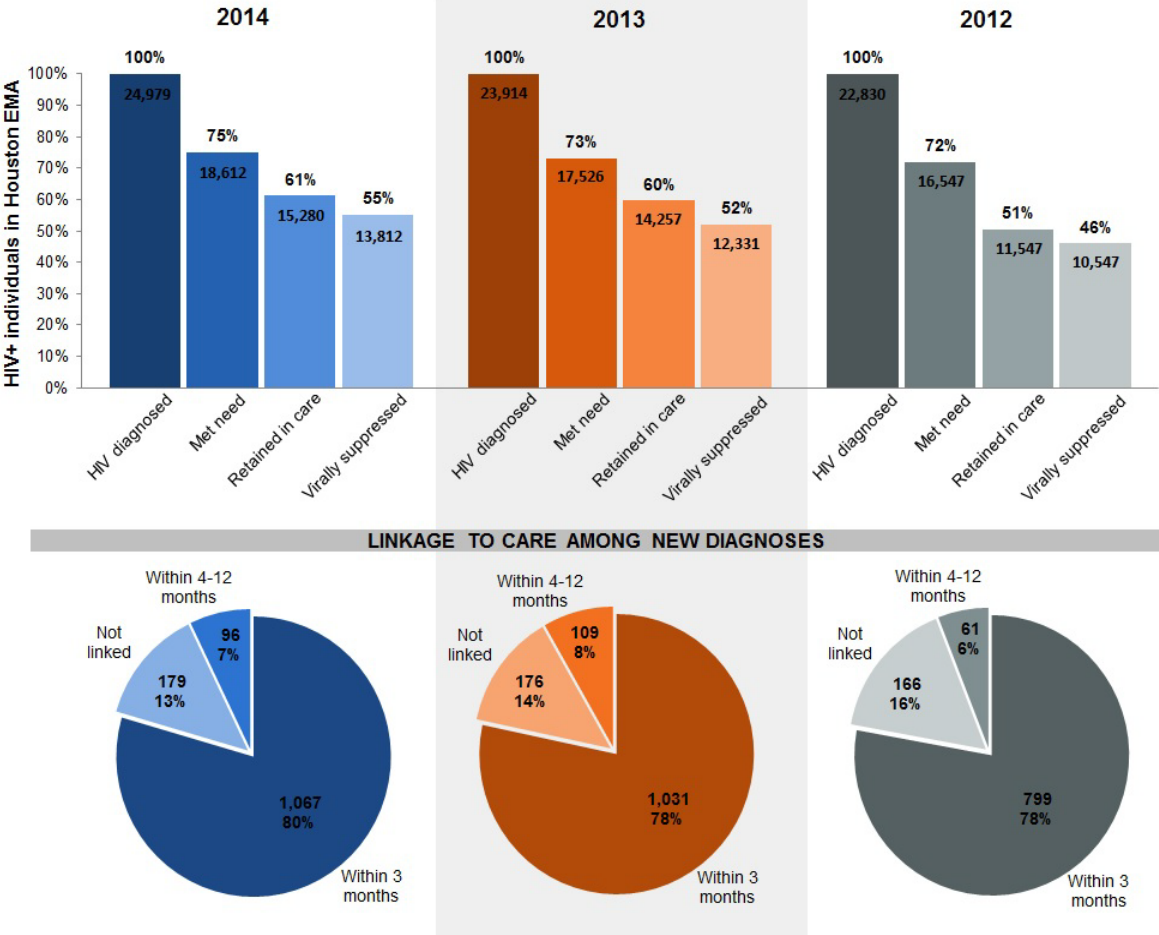
The Houston EMA Care Continuum (HCC)

The HCC is a diagnosis-based continuum. The HCC reflects the number of PLWH who have been diagnosed ("HIV diagnosed"); and among the diagnosed, the numbers and proportions of PLWH with records of engagement in HIV care ("Met need"), retention in care ("Retained in care"), and viral suppression ("Virally suppressed") within a calendar year. Although retention in care is a significant factor for PLWH to achieve viral suppression, 'Virally suppressed' also includes those PLWH in the Houston EMA whose most recent viral load test of the calendar year was <200 copies/mL but who did not have evidence of retention in care.

Linking newly diagnosed individuals into HIV medical care as quickly as possible following initial diagnosis is an essential step to improved health outcomes. In the HCC, initial linkage to HIV medical care ("Linkage to care") is presented separately as the proportion of *newly* diagnosed PLWH in the Houston EMA who were successfully linked to medical care within three months or within one year after diagnosis.

Please see the last page for the Methodology used to develop the Houston EMA HIV Care Continuum.

Figure 1: Houston EMA HIV Care Continuum, 2012-2014



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2016

From 2012-2014, the total number of HIV diagnosed increased each year, but the percentage of those with met need, retained in care, and virally suppressed also increased.

- There was a 10% increase in the percentage of persons retained in care over the course of three years, with the greatest increase from 2012-2013.
- There was a 9% increase in the percentage of those virally suppressed from 2012 to 2014.
- The percentage of those with met need and those linked within 3 months was relatively stable, with a change of 2% or less between each year.

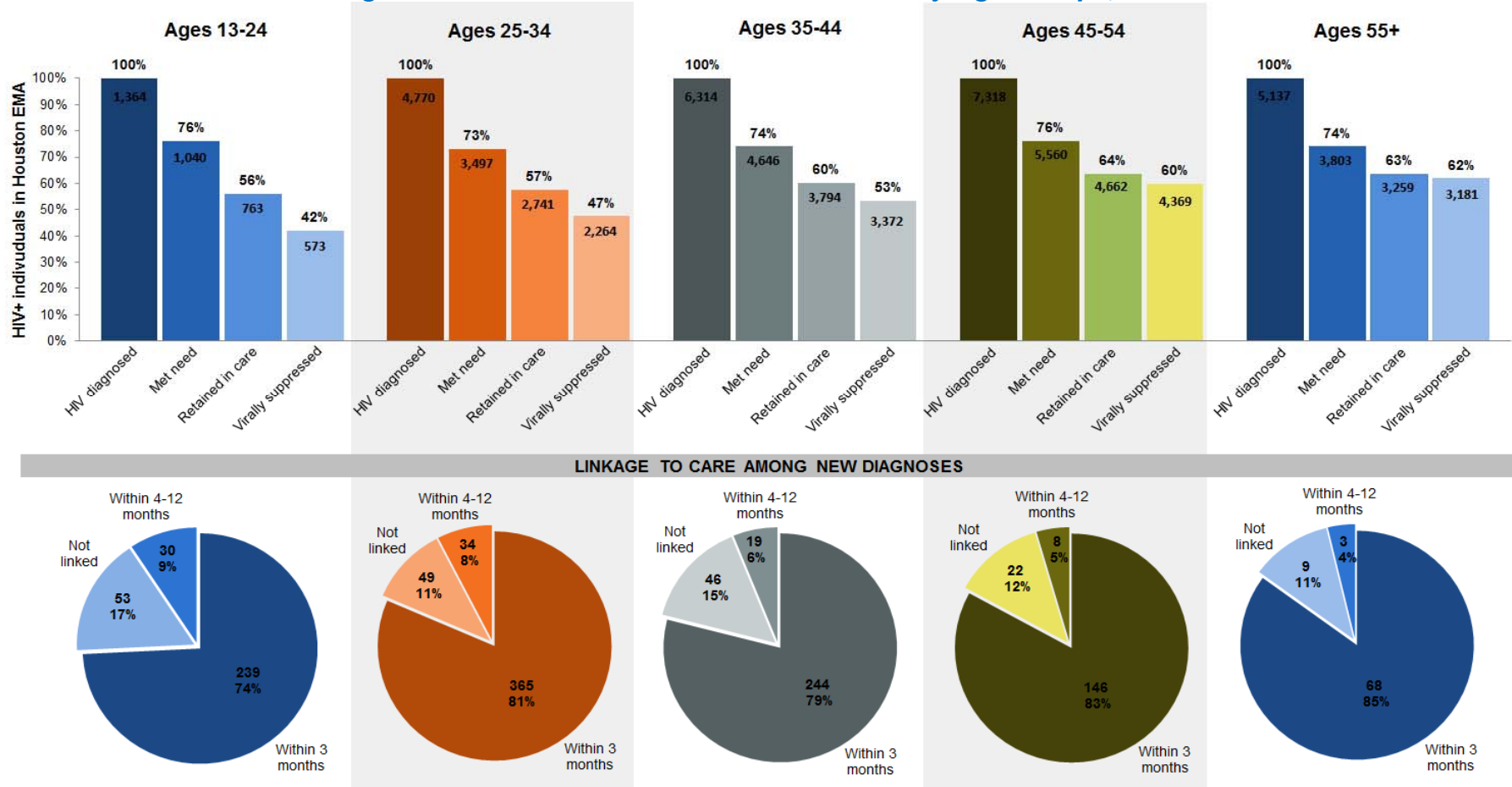
Disparities in Engagement among Key Populations

Multiple versions of the HCC have been created to illustrate engagement disparities and service gaps that key populations encounter in the Houston EMA.

It is important to note that available data used to construct each version of the Houston EMA HCC do not portray the need for activities to increase testing, linkage, retention, ART access, and viral suppression among many other at-risk key populations, such as those who are transgender or gender non-conforming, intersex, experiencing homelessness, or those recently released from incarceration

The Houston EMA Care Continuum, by Age

Figure 2: Houston EMA HIV Care Continuum by Age Groups, 2014

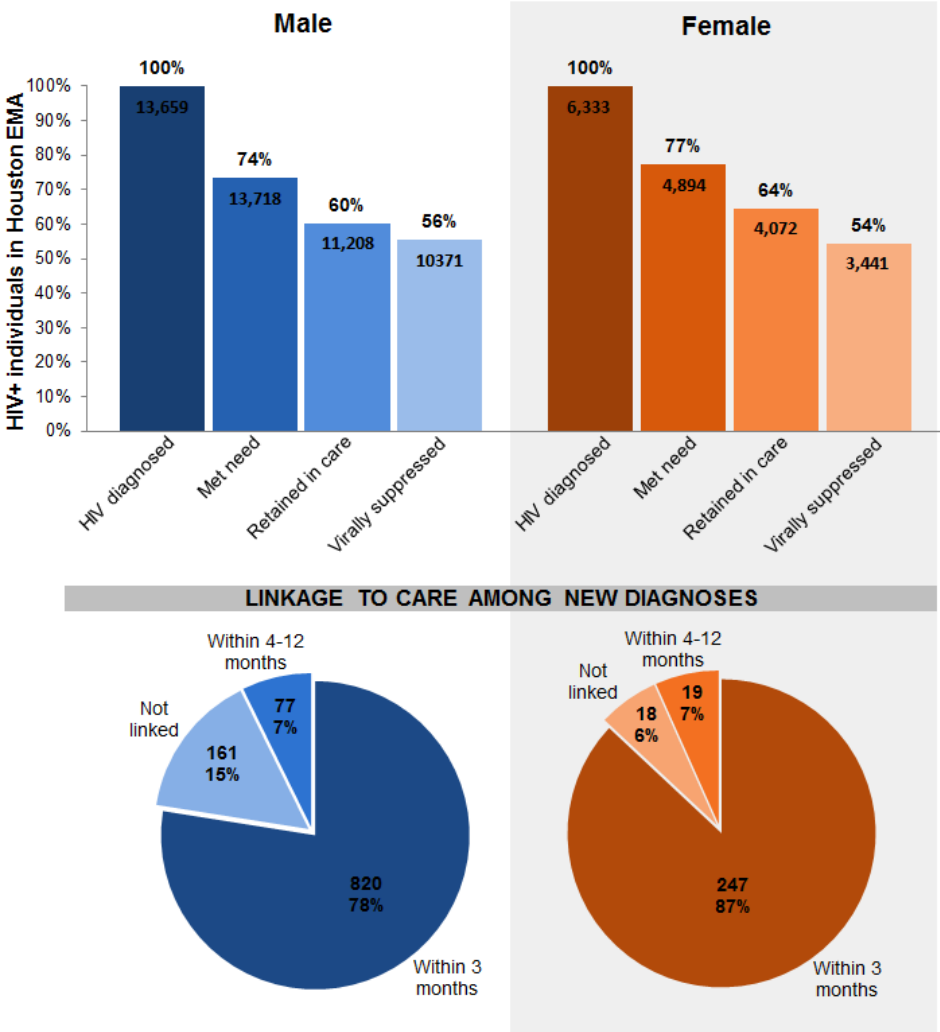


Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2016

- Younger adults had lower percentages of retention and viral suppression compared to the older adult age groups.
- Youth and young adults (13-24 years old) also had the lowest proportion of newly diagnosed PLWH who were linked within three months of diagnosis when compared to the older adult age groups.

The Houston EMA Care Continuum, by Sex at Birth

Figure 3: Houston EMA HIV Care Continuum by Sex at Birth, 2014

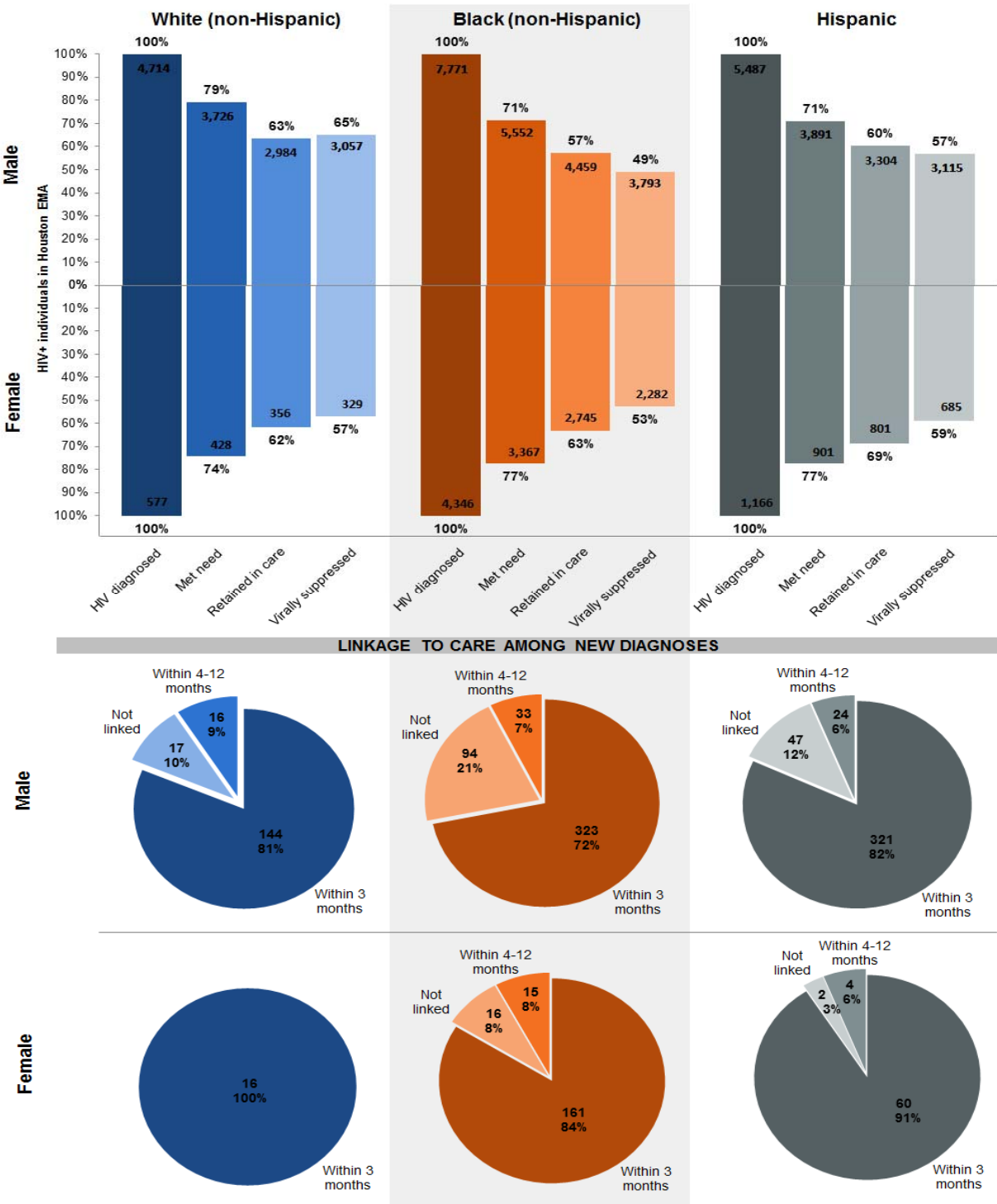


Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2016

- Females living with HIV in the Houston EMA in 2014 had a higher proportion of individuals with met need and retention in care than males living with HIV, although females had a smaller proportion of viral suppression.
- The proportion of newly diagnosed female PLWH linked to care within the first three months after diagnosis was almost 10% higher among females than males.

The Houston EMA Care Continuum, by Sex at Birth and Race/Ethnicity in 2014

Figure 4: Houston EMA HIV Care Continuum by Sex at Birth and Race/Ethnicity, 2014



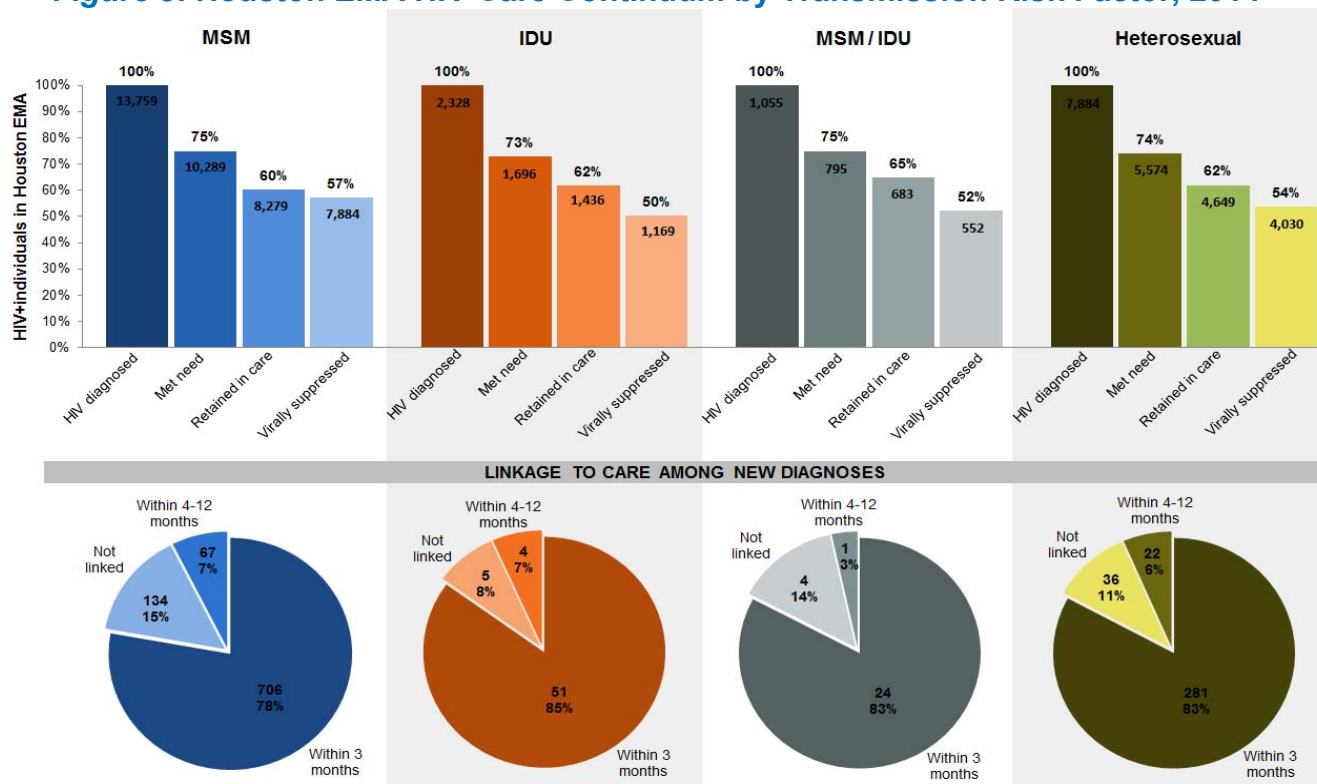
Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2016

- Hispanic and Black (non-Hispanic) PLWH had the lowest proportion of individuals with evidence of met need, retention in care, and viral suppression among males in 2014.

- Among females, White (non-Hispanic) and Black (non-Hispanic) PLWH had the lowest proportion of individuals with evidence of retention in care and viral suppression in 2014.
- Overall, Black (non-Hispanic) males living with HIV had the lowest proportion of individuals in each care continuum stage across all birth sex and race/ethnicity groups.

The Houston EMA Care Continuum, by Transmission Risk Factor in 2014

Figure 5: Houston EMA HIV Care Continuum by Transmission Risk Factor, 2014



Source: Bureau of Epidemiology and Bureau of HIV/STD and Viral Hepatitis Prevention, Houston Health Department, 2016

Transmission risk factors that are associated with increased risk of HIV exposure and transmission include Men who have Sex with Men (MSM), injection drug use (IDU), MSM who also practice IDU (MSM/IDU), and heterosexual exposure.

- Although MSM have higher numbers of PLWH than the other risk groups, the proportion of diagnosed MSM living with HIV show evidence of met need and retention in care similar to those observed for other risk groups.
- MSM also has a higher proportion of diagnosed PLWH who are virally suppressed, but a lower proportion of newly diagnosed PLWH who were successfully linked to care within three months of initial diagnosis.
- Those with IDU as a primary transmission risk factor exhibited the lowest proportions of both met need and viral suppression.

Questions about the Houston EMA HIV Care Continuum can be directed to: [Amber Harbolt](#), Health Planner in the Office of Support.

The methodology used to develop the Houston EMA Care Continuum:

Measure	Definition	Data Source(s)
HIV diagnosed	No. of persons diagnosed and living with HIV (PLWH) residing in Houston EMA through end of year (alive)	Texas eHARS data
Met need	No. (%) of PLWH in Houston EMA with met need (at least one: medical visit, ART prescription, or CD4/VL test) in year.	Texas Department of State Health Services HIV Unmet Need Project (incl. eHARS, ELR, ARIES, ADAP, Medicaid, private payer data)*
Linkage to care (pie chart)	No. (%) of newly diagnosed PLWH in Houston EMA who were linked to medical care ("Met need") within N months of their HIV diagnosis	
Retained in care	No. (%) of PLWH in Houston EMA with at least 2 medical visits, ART prescriptions, or CD4/VL tests in year, at least 3 months apart	
Virally suppressed	No. (%) of PLWH in Houston EMA whose last viral load test of the year was <200 copies/mL	Texas ELRs, ARIES labs, ADAP labs

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TO ENDING THE HIV EPIDEMIC IN HOUSTON

~December 2016~



Excerpt for How to Best Meet the Needs
Full document available at www.endhivhouston.org

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ACCESS TO CARE

The vision of the access to care work group is to ensure all residents of the Houston Area receive proactive and timely access to comprehensive and non-discriminatory care to prevent new diagnoses, and for those living with HIV/AIDS to achieve and maintain viral suppression.

Recommendation 1: Enhance the health care system to better respond to the HIV/AIDS epidemic

The ability of the local health care system to appropriately respond to the HIV/AIDS epidemic is a crucial component to ending the epidemic in Houston. FQHCs, in particular, represent a front line for providing comprehensive and appropriate access to care for people living with HIV/AIDS. While we acknowledge the commitment of many medical providers to provide competent care, ending the epidemic will require a more coordinated and focused response.

Some specific actions include:

- Develop a more coordinated and standard level of HIV prevention services and referrals for treatment, so that patients receive the same type and quality of services no matter where care is accessed.
- Integrate a women-centered care model approach to increase access to sexual and reproductive health services. Women-centered care meets the unique needs of women living with HIV and provides care that is non-stigmatizing, holistic, integrated, and gender-sensitive.
- Train more medical providers on the Ryan White care system.
- Explore feasibility of implementing a pilot rapid test and treat model, in which treatment would start immediately upon receipt of a positive HIV test.
- Better equip medical providers and case managers with training on best practices, latest developments in care and treatment, and opportunities for continuing education credits.
- Increase use of METRO Q® Fare Cards, telemedicine, mobile units, and other solutions to transportation barriers.
- Develop performance measures to improve community viral load as a means to improve health outcomes and decrease HIV transmission.
- Integrate access to support services such as Women, Infants and Children (WIC), food stamps, Children’s Health Insurance Program (CHIP), and health literacy resources in medical settings.

Ending the epidemic will require a more coordinated and focused response.

Develop cultural trainings in partnership with members of the community that address the specific cultural and social norms of the community.

Recommendation 2: Improve cultural competency for better access to care

Lack of understanding of the social and cultural norms of the community is one of the most cited barriers to care. These issues include race, culture, ethnicity, religion, language, poverty, sexual orientation and gender identity. Issues related to the lack of cultural competency are more often experienced by members of the very communities most impacted by HIV. Medical providers must improve their cultural understanding of the communities they serve in order to put the “care” back in health care. Individuals will not seek services in facilities they do not feel are designed for them or where they receive insensitive treatment from staff.

Some specific actions include:

- Develop cultural trainings in partnership with members of the community that address the specific cultural and social norms of the community.
- Include training on interventions for trauma-informed care and gender-based violence. This type of care is a treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma that contribute to mental health issues including substance abuse, domestic violence, and child abuse.
- Establish measures to evaluate effectiveness of training.
- Revise employment applications to include questions regarding an applicant’s familiarity with the community being served. New hires with lack of experience working with certain communities should receive training prior to interacting with the community.

Recommendation 3: Increase access to mental health services and substance abuse treatment

Access to behavioral health and substance abuse treatment are two of the most critical unmet needs in the community. Individuals have difficulty staying in care and adhering to medication without access to mental health and substance abuse treatment. Comprehensive HIV/AIDS care must address the prevalence of these conditions.

Some specific actions include:

- Perform mental health assessments on newly diagnosed persons to determine readiness for treatment, the existence of an untreated mental health disorders, and need for substance abuse treatment.
- Increase the availability of mental health services and substance abuse treatment, including support groups and peer advocacy programs.
- Implement trauma-informed care in health care settings to respond to depression and post-traumatic stress disorders.

Increase the availability of mental health services and substance abuse treatment.

Recommendation 4: Improve health outcomes for people living with HIV/AIDS with co-morbidities

Because of recent scientific advances, people living with HIV/AIDS, who have access to antiretroviral therapy, are living long and healthy lives. HIV/AIDS is now treated as a manageable chronic illness and is no longer considered a death sentence. However, these individuals are developing other serious health conditions that may cause more complications than the virus. Some of these other conditions include Hepatitis C, hypertension, diabetes, and certain types of cancer. When coupled with an HIV diagnosis, these additional conditions are known as co-morbidities. HIV treatment must address the impact of co-morbidities on treatment of HIV/AIDS.

Some specific actions include:

- Utilize a multi-disciplinary approach to ensure that treatment for HIV/AIDS is integrated with treatment for other health conditions.
- Develop treatment literacy programs and medication adherence support programs for people living with HIV/AIDS to address co-morbidities.

Recommendation 5: Develop and publicize complete and accurate data for transgender people and those recently released from incarceration

There is insufficient data to accurately measure the prevalence and incidence of HIV among transgender individuals. In addition, there appears to be a lack of data on those recently released from incarceration. We need to develop data collection protocols to improve our ability to define the impact of the epidemic on these communities.

Recommendation 6: Streamline the Ryan White eligibility process for special circumstances

The Ryan White program is an important mechanism for delivering services to individuals living with HIV/AIDS. In order to increase access to this program, we must remove barriers to enrollment for qualified individuals experiencing special situations. We recommend creating a fast track process for Ryan White eligibility determinations for special circumstances, such as when an individual has recently relocated to Houston and/or has fallen out of care.

Recommendation 7: Increase access to care for diverse populations

According to the 2016 Kinder Houston Area Survey, the Houston metropolitan area has become “the single most ethnically and culturally diverse urban region in the entire country.” Between 1990 and 2010, the Hispanic population grew from 23% to 41%, and Asians and others from 4% to 8%. It is imperative that we meet the needs of an increasingly diverse populace.¹⁰

Some specific actions include:

- Train staff and providers on culturally competent care.
- Hire staff who represent the communities they serve.
- Increase access to interpreter services.
- Develop culturally and linguistically appropriate education materials.
- Market available services directly to immigrant communities.

¹⁰ https://kinder.rice.edu/uploadedFiles/Center_for_the_Study_of_Houston/53067_Rice_HoustonAreaSurvey2016_Lowres.pdf

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PARTICIPANT COMPOSITION

The following summary of the geographic, demographic, socio-economic, and other composition characteristics of individuals who participated in the 2016 Houston HIV Care Services Needs Assessment provides both a “snapshot” of who is living with HIV in the Houston Area today as well as context for other needs assessment results.

(Table 1) Overall, 93% of needs assessment participants resided in Harris County at the time of data collection. The majority of participants were male (67%), African American/Black (63%), and heterosexual (54%). Greater than half were age 50 or over, with a median age of 50-54.

The average unweighted household income of participants was \$9,380 annually, with the majority living below 100% of federal poverty (FPL). Most participants paid for healthcare using Medicaid/Medicare and assistance through Harris Health System (Gold Card).

TABLE 1-Select Participant Characteristics, Houston Area HIV Needs Assessment, 2016

	No.	%		No.	%		No.	%
County of residence			Age range (median: 50-54)			Sex at birth		
Harris	464	93.4%	13 to 17	1	0.2%	Male	341	67.3%
Fort Bend	21	4.2%	18 to 24	17	3.4%	Female	166	37.7%
Liberty	1	0.2%	25 to 49	219	43.2%	Intersex	0	-
Montgomery	6	1.2%	50 to 54	123	24.3%	Transgender	20	3.9%
Other	5	1.0%	55 to 64	133	26.2%	Currently pregnant	1	0.2%
			≥65	14	2.8%			
			Seniors (≥50)	270	53.3%			
Primary race/ethnicity			Sexual orientation			Health insurance		
White	60	11.8%	Heterosexual	274	54.0%	Private insurance	53	8.6%
African American/Black	318	62.7%	Gay/Lesbian	171	33.7%	Medicaid/Medicare	307	49.8%
Hispanic/Latino	121	23.9%	Bisexual	39	7.7%	Harris Health System	146	23.7%
Asian American	5	1.0%	Other	23	4.5%	Ryan White	105	17.0%
Other/Multiracial	3	0.6%	MSM	216	42.6%	None	6	1.0%
Immigration status			Yearly income (average: \$9,380)					
Born in the U.S.	427	84.6%	Federal Poverty Level (FPL)					
Citizen > 5 years	33	6.5%	Below 100%	278	78.8%			
Citizen < 5 years	4	0.8%	100%	45	12.7%			
Undocumented	10	2.0%	150%	13	3.7%			
Prefer not to answer	22	4.4%	200%	10	2.8%			
Other	9	1.8%	250%	2	0.6%			
			≥300%	5	1.4%			

(Table 2) Certain subgroups of PLWH have been historically underrepresented in HIV data collection, thereby limiting the ability of local communities to address their needs in the data-driven decision-making processes of HIV planning. To help mitigate underrepresentation in Houston Area data collection, efforts were made during the 2016 needs assessment process to *oversample* PLWH who were also members of groups designated as “special populations” due to socio-economic circumstances or other sources of disparity in the HIV service delivery system.

The results of these efforts are summarized in Table 2.

TABLE 2-Representation of Special Populations, Houston Area HIV Needs Assessment, 2016		
	No.	%
Unstable Housing	142	28.0%
Injection drug users (IDU)*	8	1.6%
Men who have sex with men (MSM)	216	42.6%
Not retained in care (last 6 months)	4	0.8%
Recently released from incarceration	41	8.1%
Rural (non-Harris County resident)	33	6.4%
Transgender	20	3.9%

*See Limitations section for further explanation of identification of IDU



Chapter 2: Service Needs and Barriers

OVERALL SERVICE NEEDS AND BARRIERS

As payer of last resort, the Ryan White HIV/AIDS Program provides a spectrum of HIV-related services to people living with HIV (PLWH) who may not have sufficient resources for managing HIV disease. The Houston Area HIV Services Ryan White Planning Council identifies, designs, and allocates funding to locally-provided HIV care services. Housing services for PLWH are provided through the federal Housing Opportunities for People with AIDS (HOPWA) program through the City of Houston Housing and Community Development Department. The primary function of HIV needs assessment activities is to gather information about the need for and barriers to services funded by the local Houston Ryan White HIV/AIDS Program, as well as other HIV-related programs like HOPWA and the Houston Health Department’s (HHD) prevention program.

Overall Ranking of Funded Services, by Need

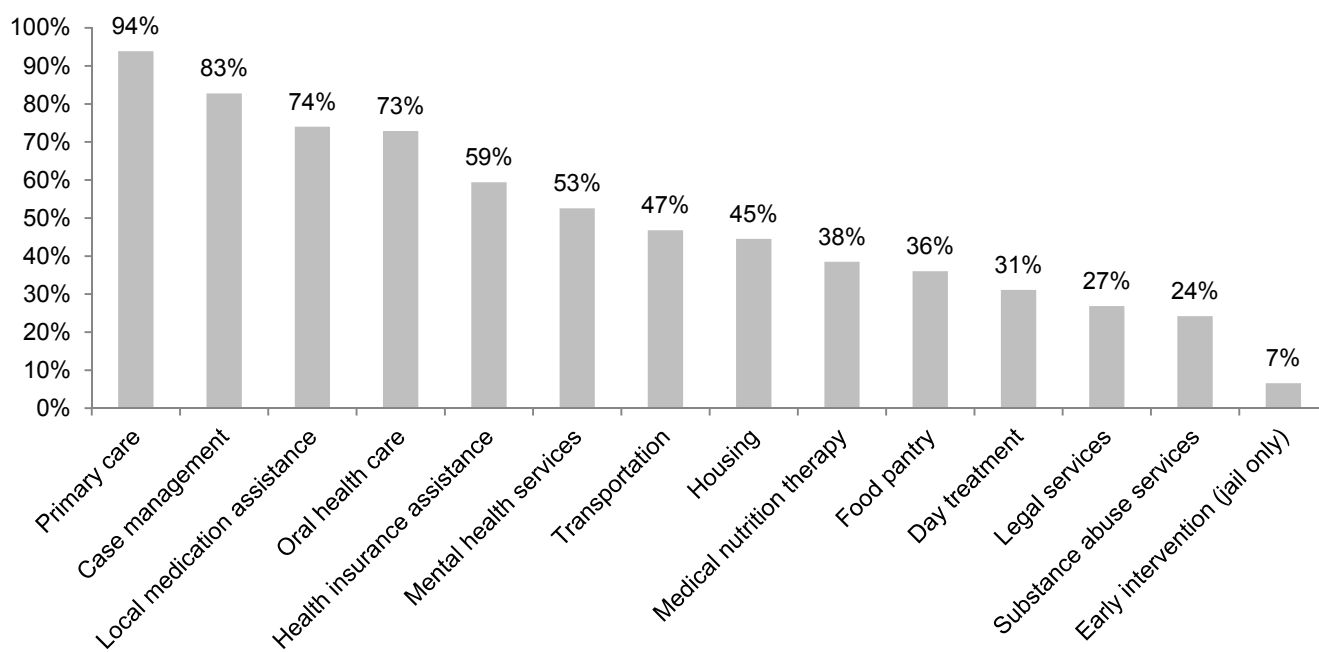
In 2016, 15 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program, and housing services were provided through the local HOPWA program. Though no longer funded through the Ryan White HIV/AIDS Program, Food Pantry was also assessed.

Participants of the 2016 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(Graph 1) All funded services except hospice and linguistics were analyzed and received a ranking of need. At 94%, primary care was the most needed funded service in the Houston Area, followed by case management at 83%, local medication assistance at 74%, and oral health care at 73%. Primary care had the highest need ranking of any core medical service, while transportation received the highest need ranking of any support service. Compared to the last Houston Area HIV needs assessment conducted in 2014, need ranking increased for many core medical services, and decreased for most support services. The percent of needs assessment participants reporting need for a particular service decreased the most for food pantry, housing, and medical nutrition therapy, while the percent of those indicating a need for health insurance assistance increased 12 percentage points from 2014, the most of any service measured.

GRAPH 1-Ranking of HIV Services in the Houston Area, By Need, 2016

Definition: Percent of needs assessment participants stating they needed the service in the past 12 months, regardless of service accessibility. Denominator:



Overall Ranking of Funded Services, by Accessibility

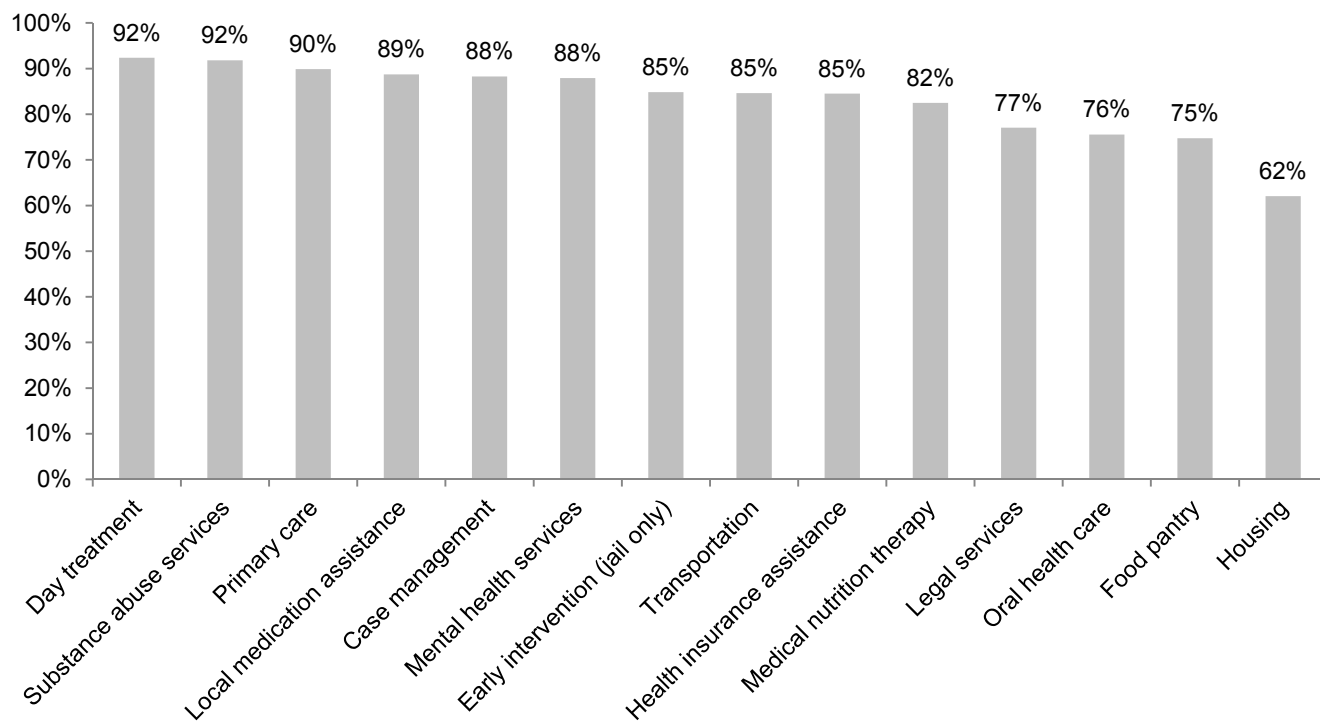
Participants of the 2016 Houston HIV Care Services Needs Assessment were asked to indicate if each of the funded Ryan White HIV/AIDS Program services they needed in the past 12 months was easy or difficult for them to access. If difficulty was reported, participants were then asked to provide a brief description on the barrier experienced. Results for both topics are presented below.

(Graph 2) All funded services except hospice and linguistics were analyzed and received a ranking of accessibility. The two most accessible services were day treatment and substance abuse services at 92%

ease of access, followed by primary care at 90% and local medication assistance at 89%. Day treatment had the highest accessibility ranking of any core medical service, while transportation received the highest accessibility ranking of any support service. Compared 2014 needs assessment, reported accessibility increased for each service category, with an average increase of 9 percentage points. The greatest increase in percent of participants reporting ease of access was observed in early intervention services, while transportation experienced the lowest increase in accessibility.

GRAPH 2-Ranking of HIV Services in the Houston Area, By Accessibility, 2016

Definition: Of needs assessment participants stating they needed the service in the past 12 months, the percent stating it was easy to access the service.



Overall Ranking of Barriers Types Experienced by Consumers

For the first time in the Houston Area HIV Needs Assessment process, participants who reported *difficulty* accessing needed services were asked to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. Recursive abstraction was used to categorize participant descriptions into 39 distinct barriers. These barriers were then grouped together into 12 nodes, or barrier types.

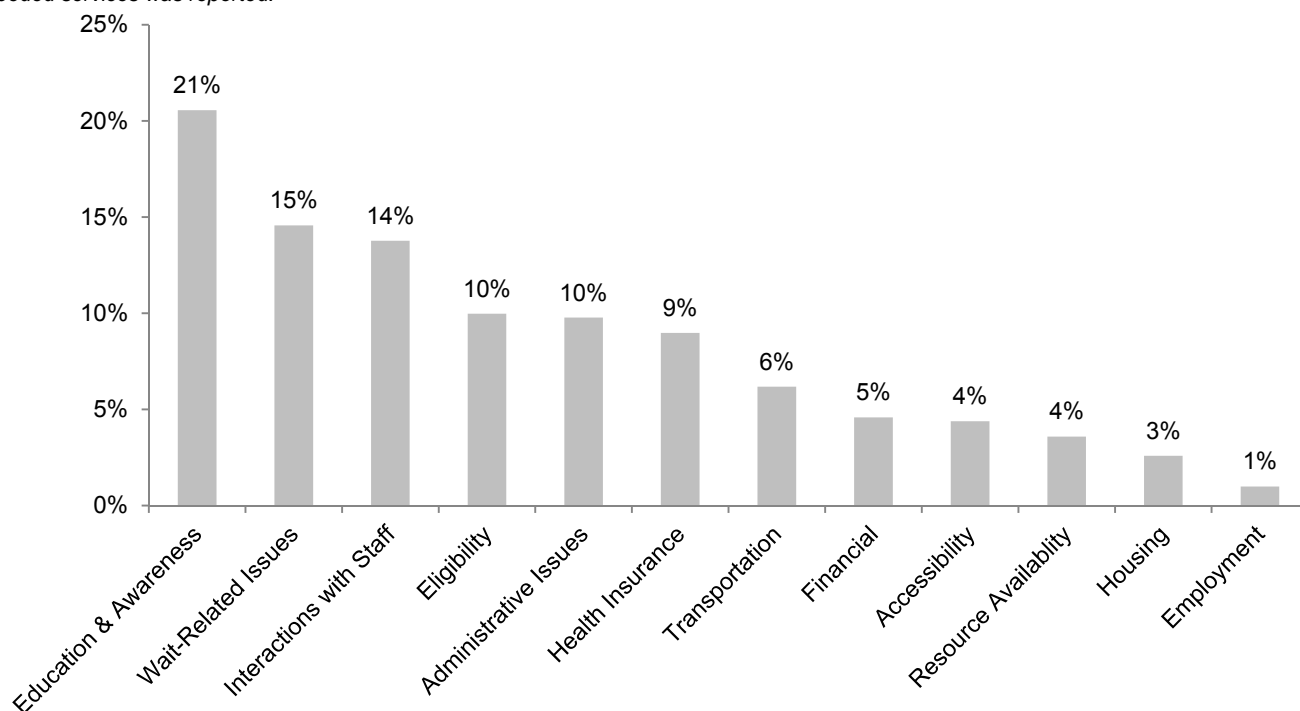
(Graph 3) Overall, the barrier types reported most often related to service education and awareness issues (21% of all reported barriers); wait-related

issues (15%); interactions with staff (14%); eligibility issues (10%); and administrative issues (10%). Employment concerns were reported least often (1%). Due to the change in methodology for barrier assessment between the 2014 and 2016 HIV needs assessments, a comparison of the change in number of reports of barriers will not be available until the next HIV needs assessment.

For more information on barrier types reported most often by service category, please see the Service-Specific Fact Sheets.

GRAPH 3-Ranking of Types of Barriers to HIV Services in the Houston Area, 2016

Definition: Percent of times each barrier type was reported by needs assessment participants, regardless of service, when difficulty accessing needed services was reported.



Descriptions of Barriers Encountered

All funded services were reported to have barriers, with an average of 33 reports of barriers per service. Participants reported the least barriers for Hospice (two barriers) and the most barriers for Oral Health Care (86 barriers). In total, 525 reports of barriers across all services were indicated in the sample.

(Table 1) Within education and awareness, knowledge of the availability of the service and where to go to access the service accounted for 82% barriers reported. Being put on a waitlist accounted for a majority (66%) of wait-related issues barriers. Poor communication and/or follow up from staff members when contacting participants comprised a majority (51%) of barriers related to staff interactions. Almost all (86%) of eligibility barriers related to participants being told they did not meet eligibility requirements to receive the service or difficulty obtaining the required documentation to establish eligibility. Among administrative issues, long or complex processes required to obtain services sufficient to create a burden to access comprised most (59%) the barriers reported.

Most (84%) of health insurance-related barriers occurred because the participant was uninsured or underinsured and experiencing coverage gaps for needed services or medications. The largest proportion (81%) of transportation-related barriers occurred when participants had no access to transportation. It is notable that multiple participants reported losing bus cards and the difficulty of replacing the cards presented a barrier to accessing other services. Inability to afford the service accounted for all barriers relating to participant financial resources. The service being offered at a distance that was inaccessible to participants or being recently released from incarceration accounted for most (77%) of accessibility-related barriers, though it is worth note that low or no literacy accounted for 14% of accessibility-related barriers. Receiving resources that were insufficient to meet participant needs accounted for most resource availability barriers. Homelessness accounted for virtually all housing-related barriers. Instances in which the participant's employer did not provide sufficient sick/wellness leave for attend appointments comprised most (60%) employment-related barriers.

TABLE 1-Barrier Proportions within Each Barrier Type, 2016

Education & Awareness	%	Wait-Related Issues	%	Interactions with Staff	%
Availability (Didn't know the service was available)	50%	Waitlist (Put on a waitlist)	66%	Communication (Poor correspondence/ Follow up from staff)	51%
Definition (Didn't know what service entails)	7%	Unavailable (Waitlist full/not available resulting in client not being placed on waitlist)	15%	Poor Treatment (Staff insensitive to clients)	17%
Location (Didn't know where to go [location or location w/in agency])	32%	Wait at Appointment (Appointment visits take long)	7%	Resistance (Staff refusal/ resistance to assist clients)	13%
Contact (Didn't know who to contact for service)	11%	Approval (Long durations between application and approval)	12%	Staff Knowledge (Staff has no/ limited knowledge of service)	7%
				Referral (Received service referral to provider that did not meet client needs)	17%
Eligibility	%	Administrative Issues	%	Health Insurance	%
Ineligible (Did not meet eligibility requirements)	48%	Staff Changes (Change in staff w/o notice)	12%	Uninsured (Client has no insurance)	53%
Eligibility Process (Redundant process for renewing eligibility)	16%	Understaffing (Shortage of staff)	2%	Coverage Gaps (Certain services/medications not covered)	31%
Documentation (Problems obtaining documentation needed for eligibility)	38%	Service Change (Change in service w/o notice)	10%	Locating Provider (Difficulty locating provider that takes insurance)	13%
		Complex Process (Burden of long complex process for accessing services)	59%	ACA (Problems with ACA enrollment process)	17%
		Dismissal (Client dismissal from agency)	4%		
		Hours (Problem with agency hours of operation)	16%		
Transportation		Financial	%	Accessibility	%
No Transportation (No or limited transportation options)	81%	Financial Resources (Could not afford service)	100%	Literacy (Cannot read/difficulty reading)	14%
Providers (Problems with special transportation providers such as Metrolift or Medicaid transportation)	19%			Spanish Services (Services not made available in Spanish)	9%
				Released from Incarceration (Restricted from services due to probation, parole, or felon status)	32%
				Distance (Service not offered within accessible distance)	45%
Resource Availability	%	Housing	%	Employment	%
Insufficient (Resources offered insufficient for meeting need)	56%	Homeless (Client is without stable housing)	100%	Unemployed (Client is unemployed)	40%
Quality (Resource quality was poor)	44%	IPV (Interpersonal domestic issues make housing situation unsafe)	0%	Leave (Employer does not provide sick/wellness leave for appointments)	60%

Waiting List Barriers and Experiences

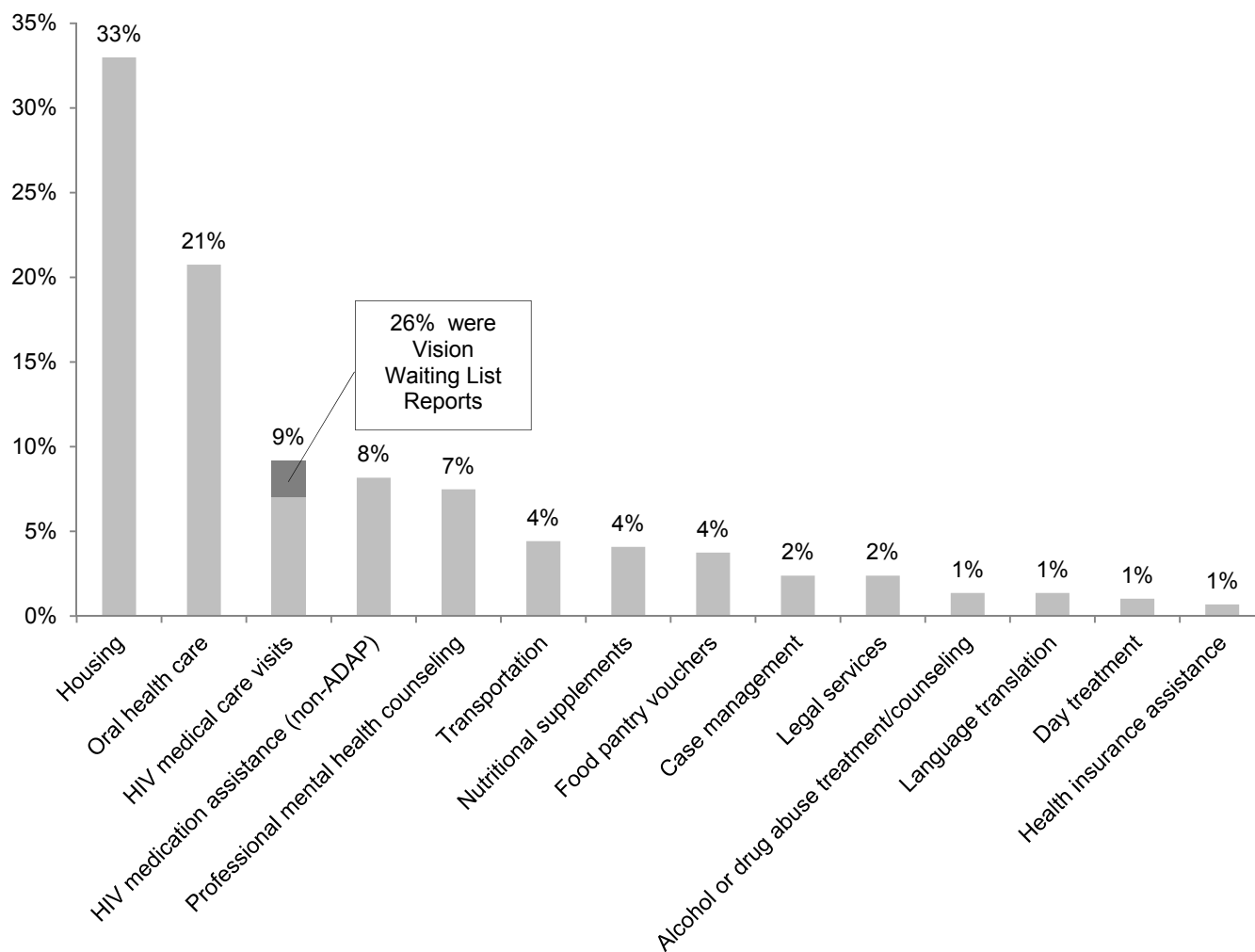
In February 2014, the Ryan White Planning Council formed the ad-hoc Waiting List Workgroup to evaluate the extent to which waiting and waitlists impact the receipt of HIV care and treatment services in the Houston Area, and propose ways to address wait-related issues through changes to the HIV care and treatment system. With input from the Waiting List Workgroup, the 2016 Houston HIV Care Services Needs Assessment included questions specifically designed to elicit information from participants about which services they had been placed on a waiting list for in the past 12 months, the time period between first request for a service and eventual receipt of the service, awareness of other providers of waitlisted services, and services for which

clients reported being placed on a waitlist more than once. Thirty-nine percent (39%) of participants indicated that they had been placed on a waiting list for at least one service in the past 12 months.

(**Graph 4**) A third of participant reports of being on a waiting list were for housing services. This was followed by oral health care (21%), HIV medical care (9%), local medication assistance (8%), and professional mental health counseling (7%). Of all participants reporting being on a wait list for HIV medical care visits, 26% indicated being placed on a waiting list specifically for vision services. There were no reports of participants being placed on a wait list for hospice or pre-discharge planning.

GRAPH 4-Percentage of Waiting List Reports by Service, 2016

Definition: Percent of times needs assessment participants reported being on a waiting list for each service.



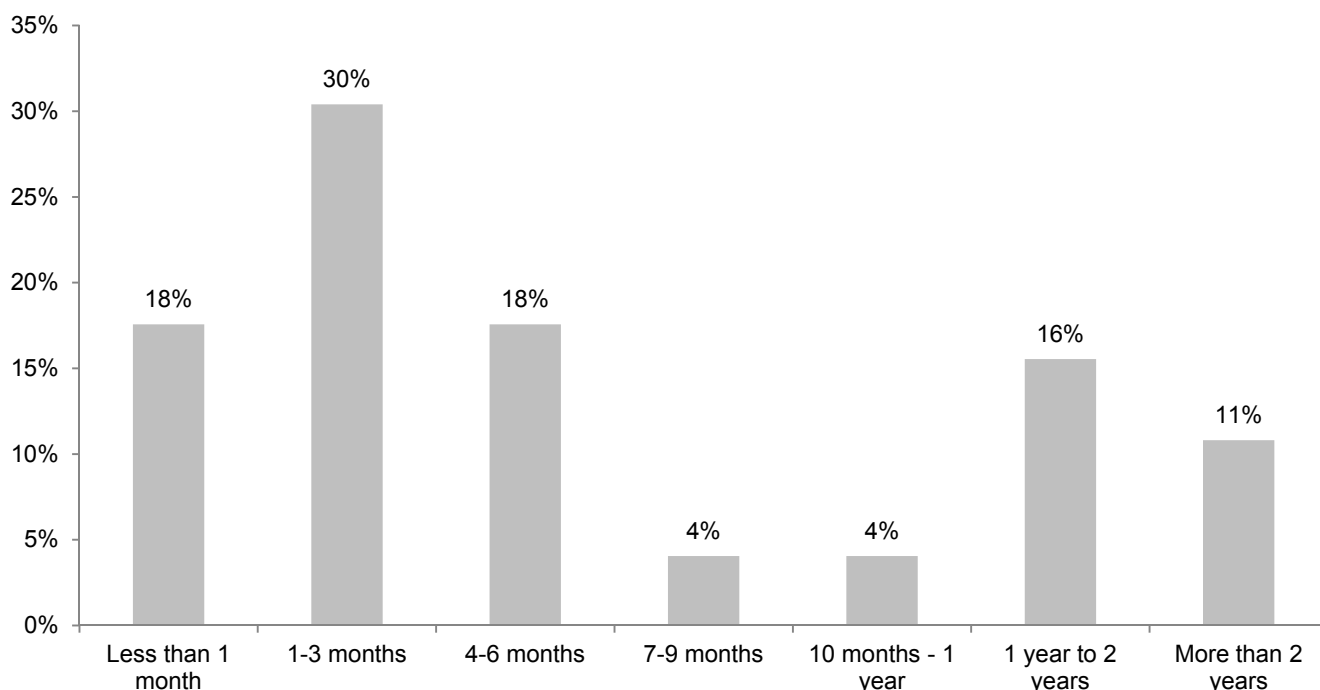
(Graph 5) Participant reports of time elapsed from the initial request for a service until receipt of the service vary from 1 day to over 2 years. The greatest number of reports of time elapsed occurred for wait times between one and three months (30%), followed by less than one month (18%) and four to six months (18%).

Most wait times reported for housing services occurred for one to three months (26%), one to two years (26%), or 10 months to one year (18%). It is worth noting that 8% of participants reporting a wait time for housing services had over two years elapse

between first request and receipt of service, with several expressing that they were on a housing wait list at the time of survey. Most reports of wait times for oral health care were less than one month (26%) or four to six months (26%). However, 14% of participants indicating a wait time for oral health care services reported wait times of over one year. Finally, most participants (64%) indicating wait times for HIV medical care including vision services reported waiting one to three months.

GRAPH 5-Percentage of Wait Times Reports, 2016

Definition: Percent of times needs assessment participants reported time elapsed from the initial request for a service until receipt of the service each time period.



Awareness of other providers for services operating waiting lists can offer timely service to consumers with acute needs and reduce wait times for those remaining on wait lists. A majority (83%) of participants who reported being on a wait list for at least one in the past 12 months stated that they were not aware of another provider of the service for which they were waiting, or did not remember if they were aware of another provider. Of the remaining 35% of participants who were aware of another

provider, over half (59%) reported not seeking service from the alternative provider.

Nearly one-third of participants who reported being placed on a wait list in the past 12 months also reported having been placed on a wait list for the service more than once. This was observed primarily for among participants reporting being placed on a wait list for housing services (34%) and oral health care (29%).

Other Identified Needs

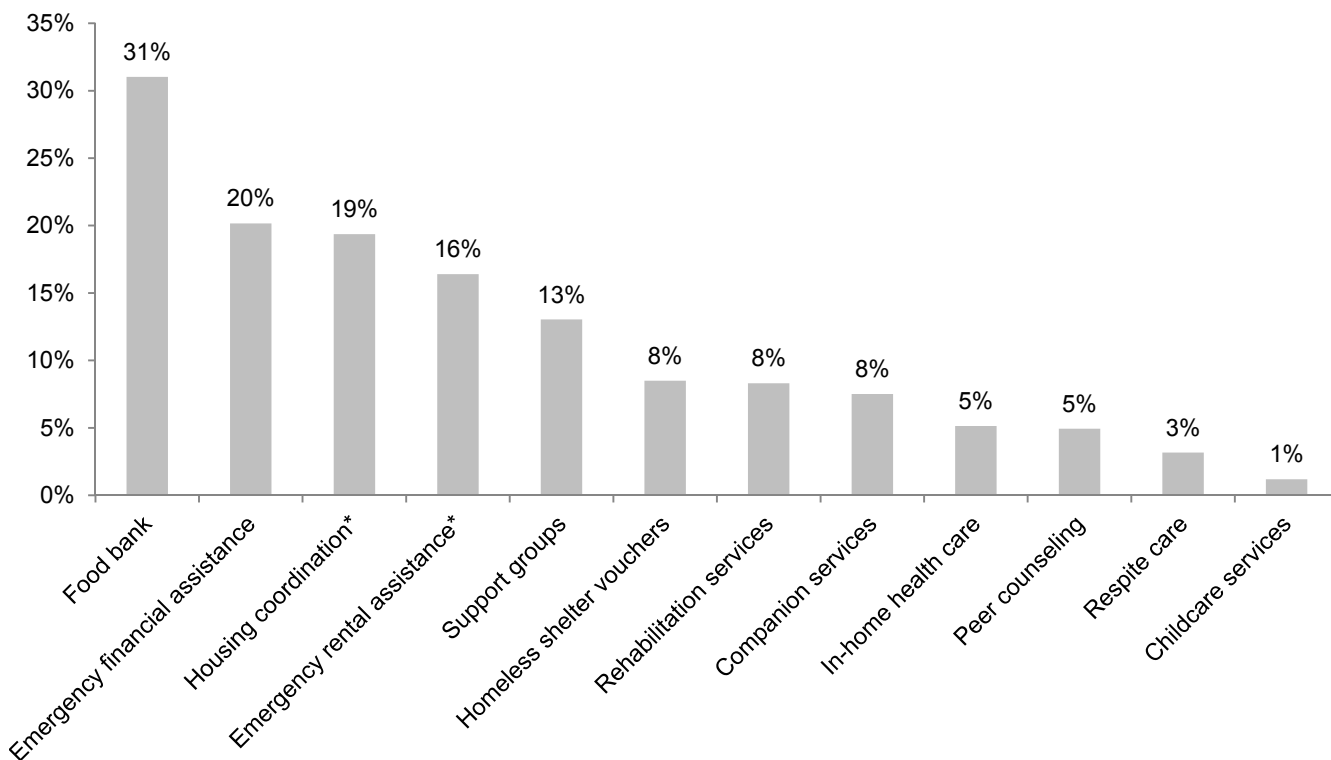
In addition to the HIV services listed above, there are other services allowable for funding by the Ryan White HIV/AIDS Program in local communities if there is a demonstrated need. Several of these other services have been funded by the Ryan White Program in the Houston Area in the past. The 2016 Houston HIV Care Services Needs Assessment measured the need for these services to order to gauge any new or emerging service needs in the community. In addition, some of these services are currently funded through other HIV-specific non-Ryan White sources, namely housing-related services provided by the Housing Opportunities with People with AIDS (HOPWA) program, as indicated.

(Graph 6) Twelve other/non-Ryan White funded HIV-related services were assessed to determine emerging needs for Houston Area PLWH. Participants were also encouraged to write-in other types of needed services. Of the 12 services options provided, 31% of participant selected food bank was needed services, a decrease of 14 percentage points from the 2014 needs assessment. Emergency financial assistance was selected second (20%), followed by housing-related services cited third (20%) and fourth (16%), and support groups cited fifth (13%).

Services that were written-in most often as a need (and that are not currently funded by Ryan White) were (*in order*): employment assistance and job training, vision hardware/glasses, and services for spouses/partners.

GRAPH 6-Other Needs for HIV Services in the Houston Area, 2016

Definition: Percent of needs assessment participants, who selected each service in response to the survey question, “What other kinds of services do you need to help you get your HIV medical care?”



*These services are not currently funded by the Ryan White program; however, they are available through the Housing Opportunities for People with AIDS (HOPWA) program.



HRSA
Ryan White & Global HIV/AIDS Programs

Ryan White HIV/AIDS Program

March 2016

BLACK/AFRICAN AMERICAN CLIENTS, 2014



Ryan White HIV/AIDS Program Black/African American Client Fast Facts

47.2% 
**OF ALL RWHAP
CLIENTS.**

79.8% 
**ARE RETAINED IN
HIV MEDICAL CARE.**

69.2% **LIVE AT OR
BELOW**
100%
**OF THE FEDERAL
POVERTY LEVEL.**

77.1% 
**ARE VIRALLY
SUPPRESSED.**

The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

RWHAP serves a significant proportion of black/African American clients living with HIV. In 2014, 73 percent of the more than half a million clients served by the Program were from racial or ethnic minority populations, with approximately 47 percent of all RWHAP clients identifying as black/African American. Below are more details about this RWHAP client population:

- ▶ **The majority of black/African American clients served by RWHAP are low income.** More than 69 percent of black/African American clients are living at or below 100 percent of the federal poverty level, which is slightly higher than the national RWHAP average (64 percent at or below 100 percent of the federal poverty level).

- ▶ **The majority of black/African American clients are male.** More than 62 percent of clients are male, nearly 37 percent are female, and just over 1 percent of clients are transgender. The proportion of black/African American males to females is slightly less than the national RWHAP average (nearly 71 percent males and 28 percent females).

- ▶ **One in six black/African American clients have temporary or unstable housing.** More than 11 percent of black/African American clients served by RWHAP have temporary housing and more than 5 percent have unstable housing.

- ▶ **Lack of health care coverage continues to impact black/African American clients served by RWHAP.** Nearly 27 percent of black/African American clients have no health care coverage, which is slightly higher than the national RWHAP average (about 25 percent).

Medical care and treatment improves health and decreases transmission of HIV. Nearly 80 percent of black/African American clients receiving HIV medical care are retained in HIV medical care. About 77 percent of black/African American clients receiving HIV medical care are virally suppressed, which is slightly lower than the national RWHAP average (more than 80 percent retained in care and more than 81 percent virally suppressed).¹

- ▶ More than 78 percent of black/African American males receiving HIV medical care are retained in care and more than 76 percent are virally suppressed.
- ▶ Approximately 82 percent of black/African American females receiving HIV medical care are retained in care and 78 percent are virally suppressed.

¹Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.





HRSA
Ryan White & Global HIV/AIDS Programs

Ryan White HIV/AIDS Program


May 2016




GAY, BISEXUAL, AND OTHER MEN WHO HAVE SEX WITH MEN (MSM), 2014

Ryan White HIV/AIDS Program Gay, Bisexual, and Other MSM Fast Facts

44.9% 
OF ALL RWHAP
CLIENTS.

25.4% **HAVE NO**
HEALTH CARE COVERAGE. 

79.4% 
ARE RETAINED IN
HIV MEDICAL CARE.

82.8% 
ARE VIRALLY
SUPPRESSED.

The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

A significant proportion of RWHAP clients are men who have sex with men (MSM). In 2014, nearly 45 percent of the more than 461,000 clients with transmission risk information served by RWHAP were MSM. Below are more details about this RWHAP client population:

- ▶ **61 percent of MSM served by RWHAP are racial and ethnic minorities.** Approximately 34 percent of MSM identify as black/African American, which is less than the national RWHAP average (approximately 47 percent). Approximately 22 percent of men identify as Hispanic/Latino, which is equal to the national RWHAP average

(22 percent). Approximately 39 percent of MSM identify as white, which is significantly greater than the national RWHAP average (about 27 percent).

- ▶ **The RWHAP MSM client population continues to increase in age.** Half of MSM are aged 45 years and older.
- ▶ **More than half (55 percent) of clients aged 13 to 24 years are MSM.** These youth and young adults represent about 7 percent of all MSM served by RWHAP.
- ▶ **About 4 percent of MSM have unstable housing situations.** This is slightly less than the national RWHAP average (about 5 percent).
- ▶ **Lack of health care coverage continues to affect MSM served by RWHAP.** Approximately 28 percent of MSM have no health care coverage, which is slightly greater than the national RWHAP average (25 percent).

Medical care and treatment improves health and decreases transmission of HIV. About 79 percent of MSM receiving RWHAP HIV medical care are retained in care, which is slightly less than the national RWHAP average (approximately 80 percent). Nearly 83 percent of MSM receiving RWHAP HIV medical care are virally suppressed, which is slightly greater than the national RWHAP average (81 percent).¹

- ▶ Approximately 72 percent of young MSM (aged 13–24) receiving HIV medical care are retained in care, and more than 65 percent are virally suppressed.
- ▶ Approximately 72 percent of young, black/African American MSM (aged 13–24) receiving HIV medical care are retained in care, and 62 percent are virally suppressed.

¹ Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.



HIV and Young Men Who Have Sex with Men



Many young people in the United States remain at risk for HIV infection. An estimated 47,500 Americans were newly infected with HIV¹ in 2010. Of these, 26%—about 12,200—were adolescents or young adults aged 13–24 years.¹ Young men who have sex with men (YMSM),^a especially black/African American^b YMSM, are at highest risk. The ongoing risk for HIV infection among YMSM underscores the need to reach each new generation with effective HIV prevention messages and services. Schools and education agencies are important partners in this effort.

Fast Facts

HIV disproportionately affects young men who have sex with men (YMSM).

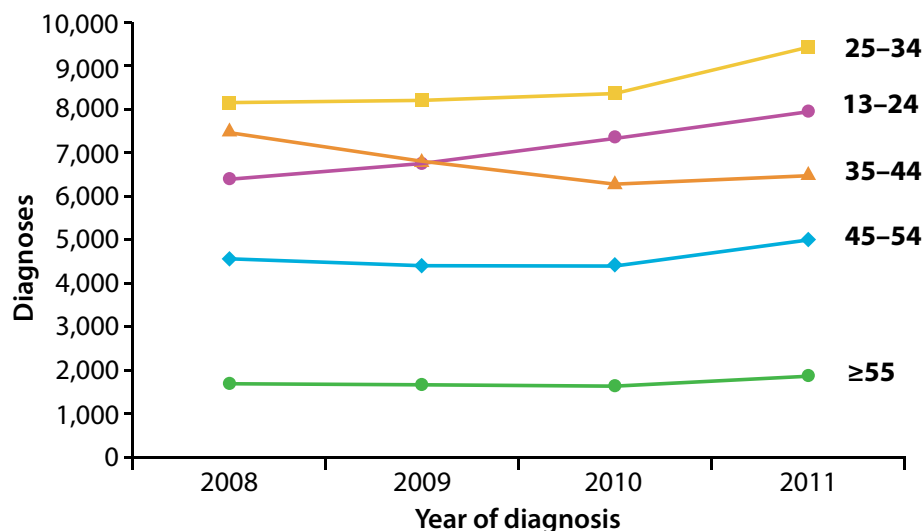
YMSM:

- In 2011, among adolescent males aged 13–19 years, approximately 93% of all diagnosed HIV infections were from male-to-male sexual contact.²
- From 2008–2011, YMSM aged 13–24 years had the greatest percentage increase (26%) in diagnosed HIV infections.³ (Figure 1)

Black and Hispanic/Latino^c YMSM:

- In 2011, among all YMSM aged 13–24 years with HIV infection, an estimated 58% were black; 20% were Hispanic/Latino.³
- Black YMSM also experienced the largest increase of all racial/ethnic groups in diagnosed HIV infections—from 3,762 diagnoses in 2008 to 4,619 diagnoses in 2011.³ (Figure 2)

Figure 1. Diagnoses of HIV Infection among Men Who Have Sex with Men, by Age Group, 2008–2011—United States and 6 Dependent Areas

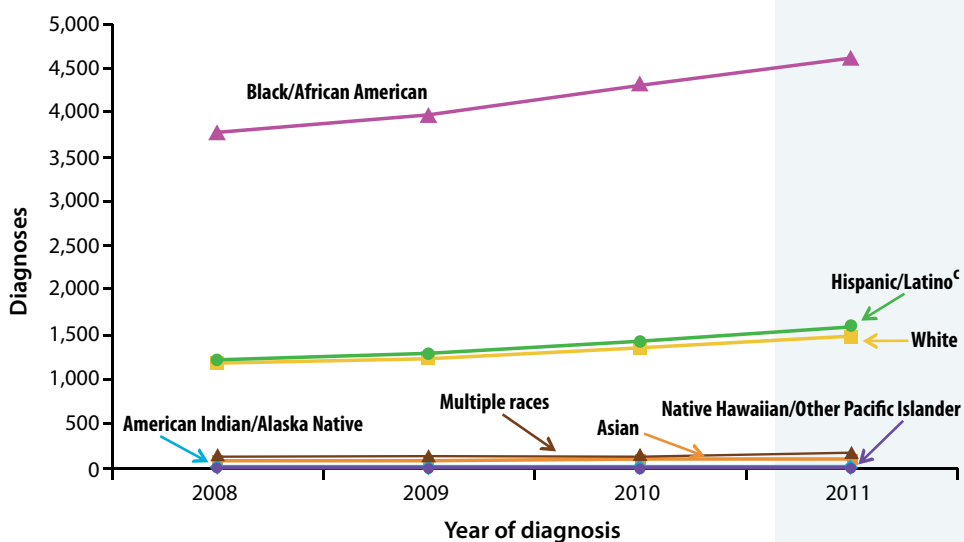


^a CDC uses the term men who have sex with men (MSM) in its surveillance systems. MSM indicates the behaviors that transmit HIV infection, rather than how individuals self-identify in terms of their sexuality.

^b Black/African American: Referred to as black in this fact sheet.

^c Hispanics/Latinos can be of any race.

Figure 2. Diagnoses of HIV Infection Among Men Who Have Sex with Men Aged 13–24 Years, by Race/Ethnicity, 2008–2011—United States and 6 Dependent Areas



HIV Prevention Challenges

The reasons for disparities in HIV infection are varied and not well understood. These disparities do not appear to reflect individual racial or ethnic differences in risk behaviors.⁴ Possible factors to explain these disparities may include the following:

- **Inadequate HIV prevention education and interventions.** Sex education programs that are not sensitive and appropriate to the needs of YMSM might not be effective in reducing sexual risk behaviors among those students.⁵
- **Limited awareness of infection.** Some HIV-infected men who have sex with men (MSM) may not know they are infected, especially MSM of color and YMSM.⁶ Those who do not know they are infected might be less likely to take measures to keep from spreading the virus to others. Getting tested for HIV is an important part of prevention.
- **Low perception of risk.** Improved treatment for HIV has helped many people with HIV infection live longer and healthier lives. YMSM, who did not witness the toll of AIDS in the early years of the epidemic, might view HIV as less dangerous and disregard risks and important prevention practices.⁷
- **Alcohol and illegal drug use.** Alcohol, methamphetamine (commonly known as “meth” or “crystal meth”), and other “party drug” use is common among some YMSM. Alcohol and drug use can lead to risky sexual behavior.⁷
- **Feelings of rejection and isolation.** Bullying, harassment, family disapproval, social isolation, and sexual violence are experienced frequently by YMSM and other sexual minority youth.⁴ These experiences can cause poor self-esteem and feelings of shame and can lead to more emotional distress, suicide attempts, substance use, and risky sexual behavior.⁸⁻¹⁰



^dThose who identify as gay, lesbian, or bisexual or who have sexual contact with persons of the same or both sexes.



School-Based Strategies for Addressing HIV Among YMSM

CDC funds state and local education and health agencies to help schools implement policies and practices to reduce health risks among sexual minority youth, including YMSM. Because black and Hispanic/Latino YMSM are at especially high risk of HIV infection, CDC collaborates with local education agencies and national nongovernmental organizations to reduce HIV and other sexually transmitted diseases (STDs) among this population. These partners are collaborating with local community-based organizations, health departments, and other health care organizations to collect data, promote safe and supportive environments, increase HIV/STD testing and treatment in schools and school-based health centers, refer students to youth-friendly health services, and implement evidence-based HIV/STD education and prevention activities.

Collect and use health risk behavior data.

Many states and large urban school districts use CDC's Youth Risk Behavior Survey (YRBS) data to monitor health risk behaviors and selected health outcomes among sexual minority students. In addition, starting in 2015, the national YRBS questionnaire and the state/local standard questionnaire will include questions about sexual identity and sex of sexual contacts. By documenting that some youth do engage in same-sex sexual activity and various health risk behaviors, YRBS data can help confirm the value of addressing the health needs of sexual minority youth in schools, adjust intervention priorities, and monitor health outcomes.

More information is available at www.cdc.gov/yrbs.

Establish safe and supportive school environments.

HIV prevention activities are more likely to have an impact if they address the challenges YMSM face at school, especially verbal harassment related to their sexual orientation.¹¹ For lesbian, gay, bisexual, or transgender students, having a safe and supportive school environment has been associated with decreases in depression, suicidal feelings, substance use, and unexcused school absences.^{12,13} To help establish supportive school environments for YMSM, schools can address bullying and sexual harassment, help students feel cared for and valued, and foster parent engagement.

Provide key sexual health services.

Linking YMSM to HIV testing and treatment is key to preventing the spread of HIV and AIDS. Confidential clinical services can help prevent new cases of HIV by increasing testing and treating HIV and other STDs. Schools can help youth access key preventive sexual health services such as HIV and STD testing, counseling, and referral, either by providing these services at schools or connecting students with community providers.¹⁴

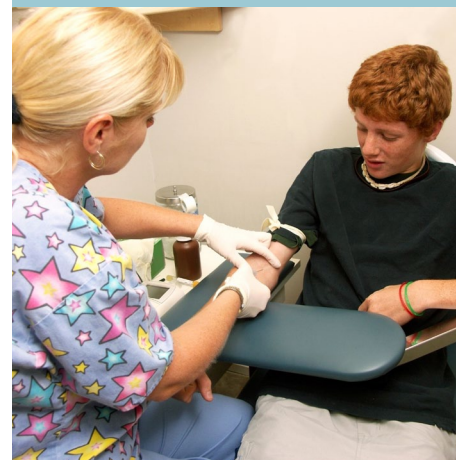
Implement exemplary sexual health education.^e

Because sexual health education programs that ignore issues in the lives of YMSM might not work effectively, schools and education agencies should ensure that health education curricula include evidence-based prevention information relevant to this population. Professional development training can help school staff understand the health needs of YMSM and shape health messages accordingly.

^e Sexual health education programs that are medically accurate, consistent with scientific evidence, and tailored to students' contexts; and that use effective classroom instructional methods.

HIV and YMSM Resources

- Evidence-based HIV prevention interventions:
www.cdc.gov/healthyouth/adolescenthealth/registries.htm
- Specific CDC-funded YMSM program activities:
www.cdc.gov/healthyouth/disparities/ymsm/
- CDC resources on school connectedness and parent engagement in school health:
www.cdc.gov/healthyouth/adolescenthealth/protective.htm
- Parental influence on sexual minority youth:
www.cdc.gov/healthyouth/protective/positiveparenting/parents_influence.htm



Getting tested for HIV is a critical part of prevention.

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Ryan White & Global HIV/AIDS Programs

Ryan White HIV/AIDS Program

May 2016

HISPANIC/LATINO CLIENTS, 2014



Ryan White HIV/AIDS Program Hispanic/Latino Client Fast Facts

22.2% 
**OF ALL RWHAP
CLIENTS.**

 **83.4%**
**ARE RETAINED IN
HIV MEDICAL CARE.**

68.3% **LIVE AT OR
BELOW**
100%
**OF THE FEDERAL
POVERTY LEVEL.**

84.0% 
**ARE VIRALLY
SUPPRESSED.**

The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

RWHAP serves a significant population of Hispanic/Latino clients living with HIV. In 2014, 73 percent of the more than half a million clients served by the Program were from racial or ethnic minority populations, and approximately 22 percent of all RWHAP clients identified as Hispanic/Latino. Below are more details about this RWHAP client population:

- ▶ **The majority of Hispanic/Latino clients are low-income.** More than 68 percent of Hispanic/Latino clients served by RWHAP live at or below 100 percent of the federal poverty level. This is greater than the national RWHAP average (64 percent).

- ▶ **The majority of Hispanic/Latino clients are male.** About 74 percent of Hispanic/Latino clients are male, about 25 percent are female, and slightly more than 1 percent of Hispanic/Latino clients are transgender. The proportion of Hispanic/Latino males compared to females is slightly higher than the national RWHAP average (about 71 percent males and 28 percent females).
- ▶ **The RWHAP Hispanic/Latino client population continues to increase in age.** About 36 percent of Hispanic/Latino clients are aged 50 years and older. An additional 16 percent are aged 40 to 49 years old.
- ▶ **About 4 percent of Hispanic/Latino clients have unstable housing situations.** This is slightly less than the national RWHAP average (about 5 percent).
- ▶ **Approximately 45 percent of all Hispanic/Latino clients are men who have sex with men (MSM).** This is the national RWHAP average of MSM clients (about 45 percent).
- ▶ **Lack of health care coverage continues to affect Hispanic/Latino clients served by RWHAP.** More than 31 percent of Hispanic/Latino clients have no health care coverage, which is higher than the national RWHAP average (about 25 percent).

Medical care and treatment improves health and decreases transmission of HIV. More than 83 percent of Hispanic/Latino clients receiving HIV medical care are retained in care, which is higher than the national RWHAP average (approximately 80 percent). About 84 percent of Hispanic/Latino clients receiving HIV medical care are virally suppressed, which also is higher than the national RWHAP average (81 percent).¹

¹ Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.





HRSA
Ryan White & Global HIV/AIDS Programs

Ryan White HIV/AIDS Program

May 2016

OLDER ADULTS, 2014



Ryan White HIV/AIDS Program Clients Aged 50 Years and Older—Fast Facts

40.4% 
**OF ALL RWHAP
CLIENTS.**

83.7% 
**ARE RETAINED IN
HIV MEDICAL CARE.**

60.6% **LIVE AT OR
BELOW**
100%
**OF THE FEDERAL
POVERTY LEVEL.**

87.6% 
**ARE VIRALLY
SUPPRESSED.**

The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

A significant proportion of RWHAP clients are aged 50 years and older. In 2014, more than 40 percent of the more than half a million clients served by the Program were aged 50 and older. Below are more details about this RWHAP client population:

- ▶ **The majority of RWHAP clients aged 50 and older are racial and ethnic minorities.** About 68 percent of clients aged 50 and older are from racial and ethnic minority populations. More than 45 percent of clients in this age group identify as black/African American, which is less than the national RWHAP average (approximately 47

percent). More than 19 percent identify as Hispanic/Latino, which is less than the national RWHAP average (22 percent).

- ▶ **The majority of clients aged 50 and older are low-income.** Nearly 61 percent of people aged 50 and older served by RWHAP live at or below 100 percent of the federal poverty level. This is less than the national RWHAP average (64 percent).
- ▶ **The majority of RWHAP clients aged 50 and older are male.** Nearly 72 percent of clients aged 50 and older are male, more than 27 percent are female, and 0.5 percent of clients aged 50 and older are transgender. The ratio of males to females in the older population is comparable to the national RWHAP average (71 percent males, 28 percent females, and 1 percent transgender).
- ▶ **About 4 percent of clients aged 50 and older have unstable housing situations.** This is slightly less than the national RWHAP average (about 5 percent).
- ▶ **Lack of health care coverage continues to affect older clients served by RWHAP.** More than 16 percent of clients aged 50 and older have no health care coverage, which is significantly less than the national RWHAP average (about 25 percent), likely because they are eligible for Medicare.

Medical care and treatment improves health and decreases transmission of HIV. Nearly 84 percent of clients aged 50 and older receiving HIV medical care are retained in care, which is greater than the national RWHAP average (approximately 80 percent). More than 87 percent of clients aged 50 and older receiving HIV medical care are virally suppressed, which is also greater than the national RWHAP average (81 percent).¹

¹ Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.



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Ryan White HIV/AIDS Program

July 2016



YOUTH AND YOUNG ADULTS, 2014

Ryan White HIV/AIDS Program Youth and Young Adults Fast Facts

5.8% 
OF ALL RWHAP CLIENTS.

75.1% 
ARE RETAINED IN HIV MEDICAL CARE.

76.0% **LIVE AT OR BELOW** 
100%
OF THE FEDERAL POVERTY LEVEL.

64.6% 
ARE VIRALLY SUPPRESSED.

The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

A significant proportion of RWHAP clients are youth and young adults. In 2014, more than 29,500 (nearly 6 percent) of the more than half a million clients served by the Program were between the ages of 13 and 24 years old. Below are more details about this RWHAP client population:

- ▶ **The majority of RWHAP clients between the ages of 13 and 24 are racial and ethnic minorities.** Approximately 63 percent of these clients identify as black/African American, which is more than the national RWHAP average (approximately 47 percent). About 19 percent of clients in this age group identify as Hispanic/Latino, which is lower than the national RWHAP average (22 percent).
- ▶ **The majority of RWHAP clients between the ages of 13 and 24 are low-income.** Seventy-six percent of these clients live at or below 100 percent of the federal poverty level. This is significantly greater than the national RWHAP average (64 percent).

- ▶ **The majority of RWHAP clients between the ages of 13 and 24 are male.** About 70 percent of clients in this age group are male, 29 percent are female, and about 1.5 percent are transgender. The proportions of male, female, and transgender clients in the youth and young adult population are similar to the national RWHAP averages (71 percent male, 28 percent female, and 1 percent transgender).
- ▶ **About 5 percent of RWHAP clients between the ages of 13 and 24 have unstable housing situations.** This is comparable to the national RWHAP average (about 5 percent).
- ▶ **Lack of health care coverage continues to affect youth and young adult clients served by RWHAP.** Approximately 33 percent of these clients have no health care coverage, which is significantly higher than the national RWHAP average (about 25 percent).

Medical care and treatment improves health and decreases transmission of HIV. Approximately 75 percent of RWHAP clients between the ages of 13 and 24 who receive HIV medical care are retained in care, which is less than the national RWHAP average (approximately 80 percent). About 64 percent of RWHAP clients in this age group who receive HIV medical care are virally suppressed, which is significantly less than the national RWHAP average (81 percent).¹

- ▶ Seventy-two percent of young men having sex with men (MSM) receiving HIV medical care are retained in care, and 65 percent receiving HIV medical care are virally suppressed.
- ▶ Seventy-two percent of young black MSM receiving HIV medical care are retained in care, and approximately 62 percent receiving HIV medical care are virally suppressed.
- ▶ Seventy-nine percent of young black women receiving HIV medical care are retained in care, and 60 percent receiving HIV medical care are virally suppressed.

¹Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.





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Ryan White & Global HIV/AIDS Programs

Ryan White HIV/AIDS Program

April 2016

FEMALE CLIENTS, 2014



Ryan White HIV/AIDS Program Female Clients Fast Facts

28.2% 
**OF ALL RWHAP
CLIENTS.**

 **82.4%**
**ARE RETAINED IN
HIV MEDICAL CARE.**

72.5% **LIVE AT OR
BELOW**
100%
**OF THE FEDERAL
POVERTY LEVEL.**



80.1% 
**ARE VIRALLY
SUPPRESSED.**

The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller, but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

RWHAP serves a significant proportion of female clients living with HIV. In 2014, more than 28 percent of the more than half a million clients served by the Program were female. Below are more details about this RWHAP client population:

- ▶ **The majority of female clients served by RWHAP are racial and ethnic minorities.** About 84 percent of female clients are from racial and ethnic minority populations. Approximately 61 percent of female clients identify as black/African American, which is higher than the national RWHAP average (approximately 47 percent). Approximately 19 percent identify as Hispanic/Latina,

which is slightly lower than the national RWHAP average (22 percent identify as Hispanic/Latino).

- ▶ **The majority of female clients are age 45 and above.** Nearly 39 percent of female clients served by RWHAP are 50 and older. Approximately 14 percent of clients are age 29 or younger.
- ▶ **The majority of female clients are low income.** 72 percent of female clients served by RWHAP live at or below 100 percent of the federal poverty level (FPL). This is above the national RWHAP average (64 percent).
- ▶ **Lack of health care coverage continues to impact female clients served by RWHAP.** Approximately 23 percent of female clients have no health care coverage, which is slightly lower than the national RWHAP average (about 25 percent).

Medical care and treatment improves health and decreases transmission of HIV. About 82 percent of female clients receiving HIV medical care are retained in care, which is slightly higher than the national RWHAP average (approximately 80 percent retained in care). Approximately 80 percent of female clients receiving HIV medical care are virally suppressed, which is slightly lower than the national RWHAP average (81 percent virally suppressed).¹

- ▶ Approximately 82 percent of black/African American females receiving HIV medical care are retained in care, and 78 percent are virally suppressed.
- ▶ Approximately 86 percent of Hispanic/Latina females receiving HIV medical care are retained in care, and 82 percent are virally suppressed.

¹ Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.





HRSA
Ryan White & Global HIV/AIDS Programs

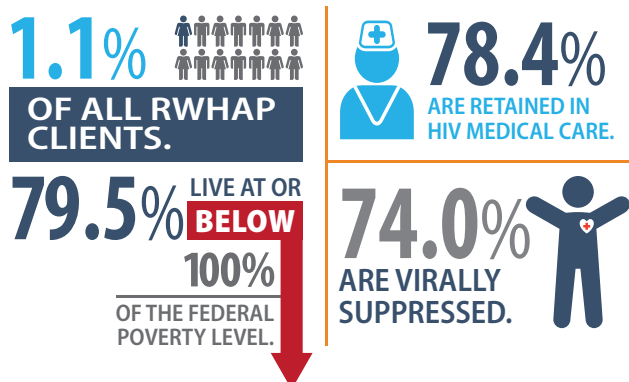
Ryan White HIV/AIDS Program

May 2016



TRANSGENDER CLIENTS, 2014

Ryan White HIV/AIDS Program Transgender Client Fast Facts



The Ryan White HIV/AIDS Program (RWHAP) works with cities, states, and local community-based organizations to provide HIV care and treatment services to an estimated 512,000 people (2014) who are uninsured or underinsured. RWHAP serves low-income and vulnerable populations of people living with HIV (PLWH). The majority of RWHAP funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and research on innovative models of care.

A critical population served by RWHAP is transgender individuals. In 2014, approximately 1.1 percent of the more than half a million clients served by the Program were transgender. Below are more details about this RWHAP client population:

- ▶ **The majority of transgender clients served by RWHAP are racial and ethnic minorities.** Approximately 88 percent of transgender clients are from racial and ethnic minority populations. About 53 percent of transgender clients identify as black/African American, which is

greater than the national RWHAP average (47 percent). About 30 percent identify as Hispanic/Latino, which is also greater than the national RWHAP average (approximately 22 percent).

- ▶ **The RWHAP transgender client population continues to increase in age.** One in five RWHAP transgender clients is aged 50 and older. An additional 28 percent are aged 40 to 49 years old.
- ▶ **About 10 percent of transgender clients have unstable housing situations.** This is greater than the national RWHAP average (about 5 percent).
- ▶ **The majority of transgender clients are low income.** More than 79 percent of transgender clients served by RWHAP live at or below 100 percent of the federal poverty level. This is significantly greater than the national RWHAP average (64 percent).
- ▶ **Lack of health care coverage affects transgender clients served by RWHAP.** Approximately 27 percent of transgender clients have no health care coverage, which is greater than the national RWHAP average (about 25 percent).

Medical care and treatment improves health and decreases transmission of HIV. 78 percent of transgender clients receiving HIV medical care are retained in care, which is slightly less than the national RWHAP average (approximately 80 percent). 74 percent of transgender clients receiving HIV medical care are virally suppressed, which is significantly less than the national RWHAP average (81 percent).¹

¹ Retention in care is based on data for PLWH who had at least one outpatient ambulatory medical care (OAMC) visit by September 1 of the measurement year, with a second visit at least 90 days later. Viral suppression is based on data for PLWH who had at least one OAMC visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.



HIV Among Incarcerated Populations

July 2015

Fast Facts

- HIV is a serious health issue for correctional facilities and their incarcerated populations.
- Most incarcerated people with HIV got the virus before entering a correctional facility.
- HIV testing at a correctional facility may be the first time incarcerated people are tested and diagnosed with HIV.

More than 2 million people in the United States are incarcerated in federal, state, and local correctional facilities on any given day. In 2010, the rate of diagnosed HIV infection among inmates in state and federal prisons was more than five times greater than the rate among people who were not incarcerated. Most inmates with HIV acquire it in their communities, before they are incarcerated.

The Numbers

- In 2012, 1.57 million people were incarcerated in state and federal prisons and at midyear 2013 there were 731,208 people detained in local jails.¹
- In 2010, there were 20,093 inmates with HIV/AIDS in state and federal prisons with 91% being men.
- Among state and federal jurisdictions reporting in 2010² there were 3,913 inmates living with an AIDS diagnosis.
- Rates of AIDS-related deaths among state and federal prisoners declined an average of 16% per year between 2001 and 2010, from 24 deaths/100,000 in 2001 to 5/100,000 in 2010.
- Among jail populations, African American men are 5 times as likely as white men, and twice as likely as Hispanic/Latino men, to be diagnosed with HIV.
- Among jail populations, African American women are more than twice as likely to be diagnosed with HIV as white or Hispanic/Latino women.

Prevention Challenges

- Lack of awareness about HIV and lack of resources for HIV testing and treatment in inmates' home communities. Most inmates with HIV become infected in their communities, where they may engage in high-risk behaviors or be unaware of available prevention and treatment resources.
- Lack of resources for HIV testing and treatment in correctional facilities. Prison and jail administrators must weigh the costs of HIV testing and treatment against other needs, and some correctional systems may not provide such services. HIV testing can identify inmates with HIV before they are released. Early diagnosis and treatment can potentially reduce the level of HIV in communities to which inmates return.
- Rapid turnover among jail populations. While most HIV programs in correctional facilities are in prisons, most incarcerated people are detained in jails. Nine out of ten jail inmates are released in under 72 hours, which makes it hard to test them for HIV and help them find treatment.
- Inmate concerns about privacy and fear of stigma. Many inmates do not disclose their high-risk behaviors, such as anal sex or injection drug use, because they fear being stigmatized. Health care providers should keep inmate's health care information confidential, know the public health confidentiality and reporting laws, and inform inmates about them.

What CDC Is Doing

Funding state, local, and territorial health departments. This is CDC's largest investment in HIV prevention. CDC funds health departments and community-based organizations (CBOs) to provide HIV prevention services in many settings, including prisons and jails.

- CDC funded selected state health departments to conduct voluntary rapid HIV testing in jails, identify previously undiagnosed cases, and refer inmates to medical care. Of the 33,211 inmates tested, 409 (1.2%) tested positive, and 269 (0.8%) undiagnosed cases of HIV were detected, many among people who had not disclosed their risk behaviors.

¹ Jails are short-term facilities that are usually run by a local law enforcement agency. Jail sentences may range from a few hours up to one year. Compared with jail facilities, prisons are longer-term facilities owned by a state or by the federal government that typically hold people sentenced to more than one year.

² State and federal jurisdictions reporting in 2010 included 37 states and the Bureau of Federal Prisons.

Funding community-based pilot projects. CDC has joined with universities, CBOs, and other partners to find out which HIV prevention interventions are most effective among incarcerated populations and how they can be applied to other settings.

- CDC supported Project START (<https://effectiveinterventions.cdc.gov/en/HighImpactPrevention/Interventions/ProjectSTART.aspx>), a pre-release HIV intervention for young men. Project participants reduced their HIV risk behaviors after their release back into the community.
- CDC funded the University of North Carolina to evaluate Project POWER (<http://www.ncbi.nlm.nih.gov/pubmed/23631715>), an HIV intervention among women in state correctional facilities. Six months after release, participants reported significantly greater condom use than nonparticipants. Participants also reported greater HIV knowledge, and more social support.
- CDC partnered with Emory University to adapt and evaluate an HIV intervention program for African American girls aged 13-17 in a juvenile detention center. Three months after the intervention, participants reported greater condom use, HIV/STD prevention knowledge, and condom use skills.
- CDC joined with Morehouse Medical School to counsel African American male jail inmates about high-risk sexual behaviors and ways to reduce them. After six months, participants reported significantly more condom use during vaginal or anal sex than nonparticipants. Participants 14-18 years old reported significantly more condom use at last sex with a non-main female sex partner than nonparticipants.

Voluntary rapid HIV testing. CDC partnered with Emory University to support voluntary rapid HIV testing at a large county jail located in a community with a high prevalence of HIV. The jail's nursing staff provided more than 12,000 tests, and 52 cases of HIV infection were newly diagnosed.

CDC has published HIV testing guidance for correctional facilities (<https://www.cdc.gov/hiv/pdf/group/cdc-hiv-correctional-settings-guidelines.pdf>) which recommends testing inmates when they enter correctional facilities, during incarceration, and just prior to release. CDC also recommends medical treatment and counseling to educate inmates about HIV risk behaviors. HIV prevention education should address male to male sex, tattooing, injection drug use, and other high risk behaviors that occur during and after incarceration.

CDC recommends that condom distribution programs be evaluated for use in prisons and jails in the United States. The World Health Organization recommends such programs (http://whqlibdoc.who.int/publications/2007/9789241596190_eng.pdf?ua=1) as an effective way to reduce HIV among incarcerated populations.

The National Center for HIV/AIDS, Hepatitis, STD and TB Prevention, (NCHHSTP) Corrections Workgroup addresses the prevention and control of HIV, STDs, Viral hepatitis, and TB among incarcerated people. The workgroup includes experts in epidemiology, criminology, and corrections issues, and works to reduce health disparities among incarcerated populations.

CDC scientists edited a special issue of the journal Women & Health, "Infectious and Other Disease Morbidity and Health Equity among Incarcerated Adolescent and Adult Women," in November 2014, which focused on the health challenges, including HIV, faced by incarcerated women.

For more information on this topic visit www.cdc.gov/hiv/group/correctional.html.

Additional Resources

CDC-INFO
1-800-CDC-INFO (232-4636)
www.cdc.gov/info

CDC HIV Website
www.cdc.gov/hiv

CDC Act Against AIDS Campaign
www.cdc.gov/actagainstaids

Sociocultural dimensions of HIV/AIDS among Middle Eastern immigrants in the US: bridging culture with HIV/AIDS programmes

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Key words

HIV risk factors; sociocultural factors; immigrants; Middle Easterners; health disparity

Abstract

The population of Middle Eastern immigrants in the US has been increasing dramatically over the past 30 years, growing from 200,000 in 1970 to 1.5 million in 2000. These immigrants and their descendants constitute an important new population of interest for public health and other social programmes. With this addition to the cultural diversity of American society, it is important for healthcare programmes to be responsive to the unique cultural needs of those of Middle Eastern origin and to include them in healthcare curricula. This need is particularly imperative for human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) intervention programmes, where the reduction of risky behaviours is essential to controlling the epidemic. When Middle Easterners emigrate to the US they must adjust to the American culture, which leads to preservation of some aspects of their culture and adjustment of behaviors to match American customs. This article aims to present sociocultural factors of HIV risk behaviours that are specific to Middle Eastern culture. The article also provides recommendations for HIV/AIDS-culturally appropriate intervention programmes.

INTRODUCTION

Middle Eastern and HIV/AIDS epidemics

One of the fastest growing populations in the US is the Middle Eastern immigrant population, having increased from 200,000 in 1970 to 1.5 million in the 2000 census.¹ Recent statistics show that 40% of the Middle Eastern immigrant population in the US comes from Arab countries.¹ In addition, a sizable portion of Middle Easterners come from non-Arab countries, including Iran, Israel, Turkey and Pakistan.¹ For the purposes of this paper, the Middle East is defined as a region including Afghanistan, Bahrain, Iran, Iraq, Jordan, Kuwait, Lebanon, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Syria, Turkey, United Arab Emirates and Yemen (Figure 1), with a population of about 460 million.^{2,3} While immigrants from this region are quite diverse in their heritage, history and languages, most Middle Easterners share a set of beliefs that are rooted in Islam.

This is an important group to investigate with regard to HIV/AIDS because, according to one study of foreign and US-born populations in Los Angeles, HIV prevalence was highest among North African/Middle Easterners compared to other immigrant populations (3.3%), with North Africa/Middle Eastern males having a prevalence of 4.1%. The same study concluded that there is a need to develop HIV-prevention materials and treatment programmes that are sensitive to the needs of Middle Eastern immigrants, since the disease affects their communities so strongly.⁴

BACKGROUND

Middle Eastern immigrants: preservation or disintegration of cultural identities?

An individual's cultural beliefs and sexual behaviours are important risk factors for HIV-acquisition.^{5,6,7} Like other immigrants, Middle Easterners find it necessary to adjust to Western

Figure 1

Middle East



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culture over time, leading to their traditional values being challenged by new cultural norms.^{7,8,9,10} The degree of adaptation and change varies within various cultural groups.^{11,12} For example, among Middle Eastern immigrants in the US, social attitudes of Arab immigrants have been found to be less Americanized than their Iranian counterparts who come from a non-Arab culture.¹¹ In addition, the degree to which previous generations of Middle Eastern immigrants acculturated in the past may be very different from newer generations.^{8,13} New generations may not preserve the

customs and traditions of their forefathers while they are living in the US or travelling back to their home countries.

Furthermore, the mobility and growth of a population impacts on the overall spread of HIV among both immigrants and non-immigrants. It has also been shown that immigrants are more likely to engage in risky sexual behaviour than non-immigrants.^{14,15} Studies of some immigrant groups have suggested that the majority of the foreign-born HIV-infected patients were infected after immigration to the US.^{15,16} This aspect of

behaviour among immigrants has not been studied in the Middle Eastern immigrant population. Therefore it is important to examine the behaviours and beliefs that might facilitate or retard risky behaviours in Middle Eastern immigrants.

Middle Eastern immigrants, particularly Arabs, usually tend to maintain their traditional customs as they explore new opportunities and take pride in their cultural heritage and identity.^{8,13,17} National origin, *per se*, does not automatically make someone more or less at risk of HIV infection. Behaviours associated with certain cultural beliefs or values may make a person more or less likely to be at risk of infection. Several features of the immigration process can affect HIV risk behaviours in this population. Immigration tends to be dominated by males and often leaves the migrant with poor prospects for marriage within his cultural group. Also the control of behaviour that is often exercised in tight-knit communities where individuals are monitored by family and neighbours is lost when one is submerged in a large foreign culture.

There is no published study on risky behaviours with regard to HIV/AIDS among Middle Eastern immigrants in the US. In addition, no culturally appropriate HIV/AIDS educational programmes for this population were found to have been developed. This may be due to the fact that most HIV educators are not familiar with the sociocultural norms, beliefs and stigmas that may increase the risk of HIV transmission in this population. Therefore this paper has been prepared to review sociocultural factors and their potential impact on risky behaviours. These include norms with regard to sexual intercourse, drug use and perinatal behaviours that might result in HIV transmission, and attitudes towards health. Understanding these cultural beliefs is crucial in order for healthcare providers to design culturally appropriate programmes for these clients.

SEXUAL TRANSMISSION

Religious culture

Islam is the fastest growing faith worldwide and in the US. It is also the second largest religion worldwide and

Bridging culture with HIV/AIDS programmes

the dominant religion in the Middle East.^{18,19} According to the US Census Bureau, in the year 2000, 73% of Middle Eastern immigrants to the US were Muslims, with a faster population growth rate than non-Muslim Middle Easterners.¹ Decades of Islamic domination and culture have influenced the Middle Eastern way of life.²⁰ HIV/AIDS challenges the religious beliefs of Middle Easterners due to the nature of the leading mode of transmission, which is sexual intercourse. Islam commands that followers practice a sexually healthy lifestyle, male circumcision and purification rituals.¹⁸ Furthermore, Islam orders that believers avoid alcohol consumption, extra- and premarital sex, anal sex, homosexuality and vaginal sex during menses.¹⁸ Adherence to these religious constraints constitutes behaviours consistent with reducing the incidence of HIV. As a result, it has been hypothesized that Islamic religious adherence is negatively related to HIV infection.²¹ Conversely, polygamy and an attitude opposed to condom use appear to increase the risks of HIV.²⁰ In addition, some sects of the Muslim faith allow the practice of 'Nikah mut'ah', which allows temporary marriage and sexual intercourse with the temporary spouse.²⁰ This marriage has a preset duration, which may be as little as one hour. After the preset time period has ended, the marriage is automatically dissolved. Multiple, sequential, temporary marriages are allowed.²²

Condom use

Condom use is seen as a sign of embarrassment, immorality and corruption in Middle Eastern culture. Embarrassment with regard to condoms in particular is a barrier to condom use.^{23,24} Condoms are allowed only within legal marriages^{18,25} and are intended for family planning.²⁰ The importance of fertility, particularly the importance of having male children,^{20,26} is deeply ingrained in Middle Eastern culture, which hinders condom use even among married people. Hence, AIDS education programmes must be sensitive to these beliefs. Therefore when educating this population, safe sex with condom use as an HIV prevention

message – particularly for singles – must be done within this cultural context.

Homosexuality

The practice of homosexuality is culturally and religiously prohibited, and if discovered may lead to community chastisement, rejection or a death sentence.^{18,27} Despite the strong prohibition and social stigma, there is an increasingly visible presence of homosexuality among Middle Easterners around the world.^{28,29} Unfortunately the fear of the disease along with societal rejection, denial and lack of education makes Middle Easterners who engage in male-to-male sex a particularly vulnerable population.

Sex industry

Approximately 50,000 people a year, most of them women and children, are trafficked to the US for illegitimate purposes including commercial sex work.³⁰ Although commercial sex is not culturally condoned, the sex industry has established itself as a mainstream business among Middle Easterners.^{31,32} The practice of Islamic religious customs of polygamy and temporary marriages can result in promiscuity, especially among immigrants who are living far from their families. Some immigrants develop 'parallel lives' when they move out of their home country. Being away from their families, friends and communities allows them a certain degree of freedom which, if taken advantage of, can lead to promiscuity.²⁰ These are populations that need to be targeted with prevention programmes. However, it must be recognized that to be seen listening to these messages is stigmatizing; it may be seen as a violation of religious and cultural norms. Even where AIDS prevention programmes and care services exist, individuals whose culture condemns those practices (in the US or their home countries) may be reluctant to participate in programmes.

Cultural beliefs and taboos on sexuality

Sexual issues and sex education are considered shameful and therefore are not discussed in families or between

sexual partners.^{7, 33,34} Cultural taboos and shame of talking openly about sex inhibit conservative families from seeking information concerning safe sex.^{7,35} Despite the important role of family communication, Middle Easterners seem less likely to supply their children with critical sexual information and HIV/AIDS education, and parents may themselves be uninformed or misinformed. School-based, in-depth, culturally sensitive programmes on sexual education and HIV/AIDS (preferably in the presence of parents or guardians) could be used to accurately and appropriately address sexuality and HIV-related risks.

Female virginity is a social value. However, the tradition surrounding it is a taboo discussion topic among Middle Easterners.²⁰ Because the bride-price for virgins is higher than for non-virgins, the social authorities or family members may impose a virginity examination.^{20,36} The prominent sign of virginity is the release of blood due to the breaking of the hymen; this evidence on a white sheet may be used later for further investigation. The absence of bleeding is considered a sign of disgrace for the bride's family and may result in shame, and in some sub-cultures, the bride's suicide or murder.^{36,37,38} To avoid the stigma attached to losing her virginity, a woman can try alternative sex like oral or anal sex. She may also attempt to 'restore' her virginity through hymenoplasty, which if performed using non-sterile techniques can lead to increased HIV risk and significant risk of other infections like hepatitis B.²⁰

Sexual subordination

The culture of patriarchy is not limited to Middle Easterners, but is highly visible and valued among them.^{39,40} Strong male authority forces women to be dependent upon the men.^{34,41} Women should be obedient to husbands and if a woman suspects that her husband has been unfaithful, she may be in danger of divorce if she voices her suspicions, initiates safe-sex practices or discusses HIV/AIDS.^{34,41,42,43} In Middle Eastern culture, sexual satisfaction is considered a priority for men, although this is largely unrecognized and even considered

inappropriate for women.^{35,44} Divorce is taboo, especially for women. If a divorced woman wishes to remarry, many sub-cultures will limit remarriage to an older man or a married man as his second wife.^{45,46}

Although increasingly common, sexual activity outside of marriage is decisively negative and stigmatizes a female's reputation.^{20,34,47} The fear of being judged or discriminated against due to immoral behaviour adds another level of distress. Additionally, a mother and her child without a legally recognized father would face shame, social neglect and ridicule. Sexual liaisons resulting in unwanted pregnancies therefore contribute to illegal abortions.²⁰ Women's risk of HIV infection is affected by sociocultural values, economic need and poor access to HIV/AIDS education.^{35,44,48} Even where sex education exists, Arab Americans tend to preserve cultural taboos on female sexuality and HIV/AIDS, which makes it more difficult for HIV/AIDS educational programmes to reach these women.⁴⁹ Most Middle Eastern Muslim women prefer or expect to have minimal casual contact with the opposite sex.^{13,50,51} The conservative culture of the Middle East can either increase women's vulnerabilities to HIV/AIDS by deterring them from seeking safe sex, or it may protect them from unsafe sex due to its conservative nature.

BLOOD-BORNE TRANSMISSION

Information on Middle Eastern immigrants' drug use and HIV transmission through injection drug users (IDUs) in the US is unavailable.²⁰ The Joint United Nations Programme on HIV/AIDS (UNAIDS) has reported that sexual intercourse is the main transmission route of HIV infection in the Middle East, followed by IDUs.⁵² There is also a high rate of drug trafficking from heroin-producing countries to Middle Eastern countries. There are approximately 400,000 IDUs in Arab countries and about 200,000 of these in Iran.⁵² According to Islam, mind-altering substances including alcohol and injection drugs are prohibited.¹⁸ Therefore information regarding needle-

replacement or needle-cleaning practices needs to be transmitted in a fashion that avoids stigmatization.

Cutting one's skin is another traditional rite that is believed to improve one's health,⁵³ cure diseases and/or furnish heavenly rewards.²⁰ This is akin to bleeding practices that were practiced in Western countries in the early 20th century. These traditional practices are possible routes of HIV transmission when conducted with non-sterile or shared devices.

ABORTION AND PERINATAL TRANSMISSION

Islam like all of the major world religions forbids abortion. Therapeutic abortion is allowed under certain conditions such as AIDS but only if carried out before four months of gestation and only after that to save the life of the mother.⁵⁴ This in turn means that Islam does not permit abortion under normal health conditions, and considers it an elaborate act of killing an innocent human being, which is a crime under any law. Those who seek illegal abortions for unwanted pregnancies are highly stigmatized.²⁰ As a result, unsafe abortions performed by untrained persons and/or in improperly equipped institutions occur. These carry a high risk of death or disability for the woman and may increase the risk of HIV infection due to the unsterile circumstances of the procedure.

Anti-retroviral therapy for an HIV-positive mother and baby before, during and after delivery can drastically reduce the risk of HIV transmission to the neonate. Fortunately, Islam does not forbid taking medication to treat life-threatening diseases. So health professionals can explain the advantages and disadvantages of anti-retroviral treatments to their Middle Eastern patients in a manner that is similar to non-Muslims. However, while avoidance of breastfeeding can reduce mother-to-child transmission, there are strong Middle Eastern cultural and Islamic commands for breastfeeding that may make this preventive practice difficult.¹⁸ Healthcare providers need to provide their patients with alternative explanations for not breastfeeding.

HEALTH AND DISEASE BELIEFS

Expression of health, diseases and death are influenced by cultural norms.^{11,55,56} Commonly, Arabs tend to underutilize health services.^{57,58} Muslims may believe that disease is a punishment from God due to sin and this is particularly true of AIDS.¹⁸ This punitive belief may prevent Muslims from seeking HIV-related services including testing, treatment and counselling. This failure to seek care and health information may even carry over to more acculturated Arabs.

Middle Easterners generally value family ties and hold family institutions in high regard; the protection of and support for families is a matter of civil, moral and spiritual value.^{59,60,61} In the Middle East, people who are ill habitually turn to their family members first for comfort, prayer and advice. Families are expected to help each other⁴¹ and be engaged in the patient's treatment and support.⁶² At least one family member usually accompanies the patient to a medical centre. It is common for a family member to stay with the patient when they are being seen by a physician to help answer questions. In Middle Eastern healthcare situations patients are only told the good news about their ailment. Physicians would normally report the significance of illnesses and consequences to a chosen family member. In the event of death or the immediate prospect of death, a guardian is designated to take care of the will and religious customs associated with burial. In the US, however, medical professionals are trained to talk frankly and directly with patients. This may have to be done more discreetly with Muslim patients and particular care must be exercised in stigmatized conditions such as HIV/AIDS. Clinicians should also be aware that if using an interpreter, their direct discussions of illnesses and their prognoses might not be accurately translated. For one thing, Middle Eastern cultural norms – particularly Islam – do not allow the discussion of certain fastidious sexual matters.⁶³ In addition, specific cultural concepts are not easily translated from one language to another.⁶⁴

Bridging culture with HIV/AIDS programmes

In Middle Eastern culture, prayer and spirituality are believed to enhance recovery and give comfort to patients and their families.⁵⁹ When patients are admitted to hospital, there is a social obligation for friends and family to visit them. This custom may be in conflict with hospital rules about number of visitors, hours of visiting, etc. Immigrants who have lived in the US for an extended time may understand these rules, reflecting the role of acculturation. However, new immigrants or the poorly acculturated may find this difficult. As a result, Middle Eastern people may postpone seeking professional treatment because they perceive that traditional methods bring psychological relief for patients and that their families may be denied to them. Therefore training and linking community leaders and traditional healers to modern health facilities is essential.^{55,60,65}

CONCLUSION

Middle Easterners are one of the fastest growing immigrant populations in the US.

Lack of valid, reliable information is a major barrier to providing effective HIV/AIDS prevention and treatment for this growing population, both in their homeland and in the US. Sex and IDU are the main HIV transmission routes, yet these are culturally and religiously stigmatized. Due to language and cultural barriers, immigrant populations may be less able to seek HIV educational information and access proper care.

It is important to highlight to Western hosts that the main HIV/AIDS risk factors (non-marital sex and IDU) are sins or against the law in most of the Middle Eastern countries. Consequently, Middle Easterners may be unwilling to disclose HIV risk behaviours. Finally, existing American HIV/AIDS intervention programmes and sexual orientation messages may not be culturally and religiously appropriate for Middle Easterners. It is strongly recommended that Middle Easterners be involved in the preparation of culturally sensitive curricula for these populations. It is particularly important to encourage religious and community leaders to take

part in the development of such programmes. These individuals will differ from community to community among immigrants of various different countries of origin (e.g. Iranians versus Saudi Arabians).

The population of Middle Easterners in the US is rapidly growing. Lack of knowledge and an unwillingness to confront detested truths are harming people by perpetuating the stigma attached to HIV/AIDS. In order to combat the HIV/AIDS epidemic effectively, it is important to understand the sociocultural risk predictors of HIV/AIDS and address them through culturally competent programmes.

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