IN IT TO END IT

OUR PLAN TO END THE HIV EPIDEMIC

2022 to 2024 Ending the HIV Epidemic Plan
New Haven/Fairfield Ryan White Program

July 2021

COLLABORATIVE RESEARCH

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New Haven Health Department

SUMMARY

VISION

The jurisdiction served by the New Haven/Fairfield Ryan White Program (NHFFRWP) will be a place where new HIV infections are prevented, every person knows their status, and every person with HIV (PWH) has high-quality care and treatment and lives free from stigma and discrimination. This vision includes all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstances.

GUIDING PRINCIPLES FOR PLANNING

- **Aspirational:** We can end the local HIV epidemic!
- **Collaborative:** Region-specific input from PWH, stakeholders, planning body members, CBO staff, etc. – all participants are equals
- **Data-Driven:** Guided by national data, local data, personal knowledge, and expertise, and PWH experience – each has merit
- **Needs-Based:** "This is what needs to be done," not "This is what's funded to be done."
- Goal-Oriented: High-impact performance expectations
- **Challenges the Status Quo:** Innovative, thoughtful strategies with public, private, programmatic, and governmental responsibilities defined

IN IT TO END IT: OUR PLAN TO END THE HIV EPIDEMIC (IITEI)

PRE-PLANNING ASSESSMENT

Review of Other Ending the HIV Epidemic Plans

Ending the HIV Epidemic plans from 25 jurisdictions of various sizes were evaluated to inform engagement strategies, goals and activities, performance metrics, content organization, and other components. This analysis was shared with the New Haven/Fairfield Counties Ryan White Planning Council and community stakeholders to prepare them for the planning process.

Review of the 2018 Connecticut Getting to Zero Report

In 2017, the Connecticut HIV Planning Consortium established the Getting to Zero (G2Z) Commission to develop recommendations to respond to the growing number of new cases of HIV in men having sex with men (MSM) of color, Black women, and transgender women. Eighteen listening sessions were conducted in New Haven, Waterbury, Bridgeport, Stamford, and Hartford. More than 200 individuals participated. The G2Z report details city-specific activities and six overarching recommendations for the ambitious goal of "getting to zero."

Interviews with Leaders in the HIV Community

Between April and October 2020, interviews were conducted with more than 25 HIV community leaders in each Region, representing PWH, local planning body leadership, HIV prevention and care program leads, pharmaceutical company representatives, community-based organizations, NHFFRWP staff, and others. Participants were asked to share their thoughts on the current HIV services in their Region, high-priority prevention/care service gaps, the level of community engagement in HIV issues, opportunities for innovative service delivery (rapid start, self-test kit distribution, etc.), and policy issues. These interviews provided an overview of HIV prevention and care planning, and service delivery in the

jurisdiction. Responses were compiled and organized into four themes: Service Improvements, Education and Awareness, Disruptive Innovation, and Infrastructure Changes. Within these themes, 17 issues were identified. Five of these issues align with the recommendations of the 2018 Getting to Zero report: Establishing region-specific HIV planning, PrEP/PEP education, statewide HIV media and marketing, HIV education and training for providers, and policy initiatives to promote routine HIV testing. A Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis was completed for each of the 17 issues by organizing the comments made by community leaders into appropriate groupings.

Review of the Ryan White Program's Continuous Quality Improvement Goals

Goal 1: Increase linkage to HIV care in newly diagnosed persons.
Objective: Increase linkage to HIV care in newly diagnosed persons from 64% to 75%.

Goal 2: Improve health outcomes for PWH.
Objective: By the end of FY2020, increase viral load suppression among persons in HIV medical care from 90% to 93%.

Goal 3: Reduce HIV-related disparities and health inequities.
Objective 1: By the end of FY2020, increase viral load suppression among black women, transgender women of color, and young MSM of color by 5%.

Objective 2: In FY2020, at least 90% of clients receiving medical case management services are actively engaged in medical care as documented by at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.

Goal 4: Achieve a more coordinated statewide response to the HIV epidemic.
Strengthen collaboration between HIV prevention and care partners.

COMMUNITY ENGAGEMENT
More than 200 PWH and others informed the development of the 2018 Connecticut Getting to Zero (G2Z) report. Rather than duplicate this effort, a complimentary engagement strategy to inform IITEI was established. Stakeholders were divided into two groups:

- PWH and the Community
- Planning Bodies, Task Forces, and Providers

Due to social distancing mandates implemented in response to the Covid-19 pandemic, all community engagement sessions were conducted online using the Zoom virtual meeting platform.

INPUT FROM PWH AND THE COMMUNITY
Participants of this group included:

- PWH who were not members of a planning body, task force, or staff at an agency
- People at risk of acquiring HIV
- Affected community members
- Black faith leaders and members of the Black faith community

Since the 2018 G2Z initiative had used a relatively formal focus group structure for community engagement, feedback sessions for IITEI were designed to be small and informal. Participants were asked to share their thoughts and perceptions on sexual health, accessing services, and what they thought could be done to end the HIV epidemic in their communities. More than 60 people participated in these robust conversations.

During the discussions, graphic recorders created visualizations of the stories, themes, and comments. The final discussion boards provide a captivating record of each engagement session, conveying emotion and intent better than a written report can. Participants see their words come to life, and those viewing the boards have a greater sense of the tone and content of the meeting. The discussion boards can be displayed during later meetings for reference, shared online, and provided to participants as a souvenir of the session.

INPUT FROM PLANNING BODIES, TASK FORCES, AND PROVIDERS

Participants of this group included:

- Staff of community-based organizations providing HIV prevention and care services
- Staff of state and local HIV/STD/Hep-C public health programs (care and prevention programs)
- Staff of HIV/STD testing centers
- Members of planning councils, task forces, and other local HIV planning bodies or community groups
- HIV medical providers
- Elected and non-elected community leaders

The engagement strategy for IITEI was designed to gather feedback from people who often have little to no direct input in HIV planning. Community-based organizations and health programs were asked to have their entire staff take part and share their passion, knowledge, and expertise. Perhaps for the first time, front desk personnel, case managers, bookkeepers, and others not involved in face-to-face service delivery had a voice in HIV planning. Between November 2020 March 2021, more than 115 individuals participated in a facilitated activity to answer a single, straightforward question:

"What needs to happen in the next two to five years that will result in the end of the HIV epidemic in Connecticut?"

Participants generated ideas using a combination of individual brainstorming, two-member team review, and large group discussion. They then grouped these ideas based on common themes. Finally, they named specific strategies based on these groupings. The result of each session was a unique range of strategies and activities that would contribute to ending the HIV epidemic.

ANALYSIS OF STAKEHOLDER INPUT

Community input gathered from engagement sessions, interviews with HIV leaders, and the 2018 Connecticut Getting to Zero Report was organized by strategy. Then, each group's priority for a strategy was determined based on the amount of discussion and number of ideas that were generated. Then, commonalities were identified. Finally, discussion topics, comments, and ideas generated by each group were analyzed to develop the framework for each strategy and define individual activities.

GOALS AND STRATEGIES

Strategies are organized according to the goals of the HIV National Strategic Plan.

GOAL 1: PREVENT NEW HIV INFECTIONS

Strategies for Implementation by the New Haven/Fairfield Ryan White Program

- Adopt the Status Neutral Prevention and Treatment Cycle (SNPTC) as the EMA's framework for rapid linkage to HIV, hepatitis, and STI care, or PrEP/PEP initiation.
- Implement an Undetectable=Untransmittable (U=U) educational initiative for Ryan White clients.

Recommended Strategies for Community Implementation

- Complete detailing activities to increase the number of medical providers offering PrEP and PEP services in geographic areas with high HIV incidence.
- Increase the number of entities providing HIV, hepatitis, and STI testing in geographic areas of high HIV incidence, including non-traditional partners such as walk-in labs, pharmacies, and mobile testing services.
- Develop and implement a community-informed PrEP/PEP media initiative, with specific messaging for young Black and Hispanic MSM, Transgender women and men, and Black women.

GOAL 2: IMPROVE HIV-RELATED HEALTH OUTCOMES OF PEOPLE WITH HIV

Strategies for Implementation by the New Haven/Fairfield Ryan White Program

- The NHFFRWP will establish a rapid linkage to care protocol as a required component of service delivery. This protocol will link all newly diagnosed PWH, or those who were previously diagnosed and returning to care, to their first medical appointment within seven days of identification.
- Develop and implement a pilot program to adapt the Contingency Management model used in substance use services to HIV care (provision of motivational incentives and tangible rewards to PWH who are erratically engaged in care).
- Develop and implement a jurisdiction-wide presentation series to promote best practices in HIV care and prevention and ignite conversation about local issues that impede progress toward ending the local HIV epidemic.
- Complete detailing sessions to increase provider knowledge of the availability of Ryan White-funded medical care, supportive services, and linkage to care systems.

Recommended Strategies for Community Implementation

- Train medical providers to expand their ability to offer high-quality, affirming, and sex-positive medical care to LGBTQ+ people, including PrEP/PEP services and HIV, hepatitis and STI testing and treatment.

GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES

Strategies for Implementation by the New Haven/Fairfield Ryan White Program

- Develop a system-wide approach for HIV service delivery using the "designing for the margins" model to reach marginalized populations that have experienced forms of systemic exclusion such as structural racism, poverty, gender and sexuality-based discrimination, incarceration, trauma, mental illness, and substance use disorder.
- Engage Black faith leaders to educate their congregations and communities on HIV to increase awareness and reduce stigma and discrimination toward PWH. Incorporate faith-based initiatives into NHFFRWP quality improvement activities.
- Complete an assessment of the HIV-related stigma and discrimination experienced by PWH.

Recommended Strategies for Community Implementation

- Advocate for the passage of legislation to establish routine HIV screening in emergency rooms, hospitals, urgent care centers, and other clinical settings, and as a part of prenatal care for pregnant women.
- Advocate for the passage of legislation or changes to school board policies that support comprehensive, age-appropriate, LGBTQ+ inclusive, sex-positive sex education curricula in Connecticut middle and high schools.
- Develop and implement community-informed media initiatives to increase general knowledge of HIV and modern methods of HIV prevention and treatment.

GOAL 4: ACHIEVE INTEGRATED, COORDINATED EFFORTS THAT ADDRESS THE HIV EPIDEMIC AMONG ALL PARTNERS AND STAKEHOLDERS

Strategies for Implementation by the New Haven/Fairfield Ryan White Program

- Analyze Ryan White program data and state/local epi data to evaluate viral suppression among clients based on service use, provider, geographic area, demographics, etc. Identify opportunities that support increased retention in care. Priority zip codes for reengaging out of care/lost to care clients are 06704, 06705, 06902, 06854, 06810, and 06811.

Recommended Strategies for Community Implementation

- Reestablish the Connecticut State Department of Health’s common data collection and reporting system. This will support local health departments and community-based organizations to complete data-driven HIV, hepatitis, and STI disease investigation activities, engage out-of-care PWH into care, and address geographic disparities in real time.
- Engage PWH, Ryan White Programs, planning bodies, and community stakeholders to evaluate the status of current relationships and establish a shared vision and structure for future collaboration.

IN IT TO END IT: OUR PLAN TO END THE HIV EPIDEMIC

VISION

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ABOUT THE NEW HAVEN/FAIRFIELD EMA

The New Haven/Fairfield Ryan Program (NHFFRWP) receives funding from the Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program to provide core medical and support services for people living with HIV in the eligible metropolitan area (EMA) of New Haven and Fairfield County, Connecticut and its five subregions: New Haven, Bridgeport, Waterbury/Meriden and the Naugatuck Valley, Stamford/Norwalk, and Danbury.

The NHFFRWP serves over 2,000 clients, primarily people of color (80% African Americans and Latinos), with a focus on populations that have experienced a recent increase in HIV transmission.

PRIORITY POPULATIONS

- Gay, bisexual, and other men who have sex with men (MSM), especially young Black and Hispanic MSM
- Transgender women and men
- Black women

NEW HIV CASES, NEW HAVEN EMA, 2010 TO 2019

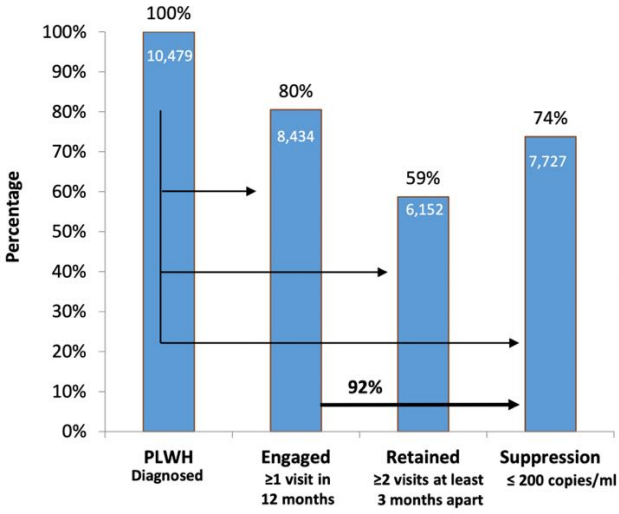
Figure 1: HIV Infection Cases by Year of Diagnosis, Sex, Race, Risk, and Age Group, New Haven/Fairfield Counties EMA, 2010 - 2019

		Sex		Race/ethnicity				Transmission Category							Age at diagnosis			
	Total	Female	Male	Black/African American	Hispanic/Latino	Other races	White	Heterosexual contact	MSM	MSM and IDU	PWID	Perinatal	Presumed Heterosexual contact	Unknown	<13	13-19	20-44	45+
	Number	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
Diagnosis Year																		
2010	202	31.7	68.3	49.0	26.2	1.0	23.8	35.1	36.1	1.5	11.9	0	6.4	8.9	0	5.9	60.4	33.7
2011	186	26.3	73.7	44.6	25.8	2.2	27.4	30.6	41.4	2.2	7.0	0.5	4.8	13.4	0	3.2	62.9	33.9
2012	173	27.2	72.8	49.1	25.4	2.3	23.1	31.8	45.7	1.2	8.1	0	3.5	9.8	0	5.2	65.9	28.9
2013	178	19.1	80.9	39.3	32.0	2.2	26.4	29.8	50.0	0.6	9.6	1.1	0.6	8.4	0.6	5.6	57.9	36.0
2014	186	28.0	72.0	49.5	25.3	2.7	22.6	30.6	48.9	1.1	5.9	0	5.4	8.1	0	4.3	60.8	34.9
2015	147	23.8	76.2	43.5	29.3	2.7	24.5	27.2	55.1	2.7	4.1	0	4.1	6.8	0	3.4	63.9	32.7
2016	169	20.1	79.9	44.4	29.0	3.6	23.1	23.7	58.0	2.4	3.6	0	2.4	10.1	0.6	2.4	66.9	30.2
2017	151	27.8	72.2	47.7	28.5	3.3	20.5	33.1	47.7	2.6	6.0	0	1.3	9.3	0	5.3	62.9	31.8
2018	136	26.5	73.5	48.5	25.7	3.7	22.1	29.4	51.5	2.2	2.2	0	6.6	8.1	0	3.7	59.6	36.8
2019	112	26.8	73.2	46.4	24.1	5.4	24.1	23.2	53.6	0	5.4	1.8	3.6	12.5	0.9	6.3	61.6	31.3
Total	1,640	25.8	74.2	46.2	27.2	2.7	23.8	29.8	48.2	1.6	6.6	0.3	3.9	9.5	0.2	4.5	62.3	33.0

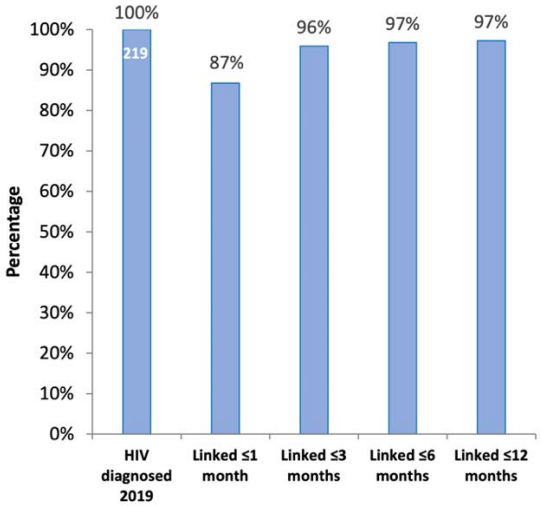
This table presents HIV Infection cases using the year the person was first diagnosed. The term HIV Infection is used to refer to three categories of diagnoses collectively:
1 - persons with a diagnosis of HIV infection (not AIDS)
2 - a diagnosis of HIV infection and a later diagnosis of AIDS
3 - concurrent diagnoses of HIV and AIDS.

Source: HIV Surveillance Registry for cases reported through December 23, 2020
Data provided by the Connecticut State Department of Public Health

Figure 2: HIV Continuum of Care, Connecticut, 2019



Based on persons receiving HIV care in 2019 among persons ≥13 years old at diagnosis, resided in Connecticut (based on most recent residence) and diagnosed with HIV infection through 2018 and living with HIV on 12/31/2019. A visit is defined as a CD4, viral load, or genotype test result during the evaluation period. The overall HIV population may be overestimated because 2019 deaths are preliminary. Source: HIV Surveillance Registry for cases reported through December 2020.



Based on the number of persons ≥13 years old, diagnosed with HIV in 2019, who resided in Connecticut (based on residence of HIV diagnosis) and were linked to care within 1, 3, 6, 12 months after HIV diagnosis. Source: HIV Surveillance Registry for cases reported through December 2020.

Data provided by the Connecticut State Department of Public Health

Additional epidemiological data for the jurisdiction can be found in Appendices 3 to 7.

ENDING THE HIV EPIDEMIC: A PLAN FOR AMERICA AND THE HIV NATIONAL STRATEGIC PLAN

On February 5, 2019, President Donald J. Trump announced his Administration's goal to end the HIV epidemic in the United States. Ending the HIV Epidemic: A Plan for America (EHE) established a strategic plan to reduce new HIV infections in the United States by 75 percent in five years and by 90 percent by 2030.

In January 2021, an updated HIV National Strategic Plan for 2021 to 2025 (HNSP), the nation's third consecutive national HIV strategy, was released. The HNSP and EHE initiatives are closely aligned and complementary, with EHE serving as a leading component of the work by the U.S. Department of Health and Human Services (HHS), in collaboration with local, state, federal, and community partners, to achieve the common goal. The EHE initiative addresses jurisdictions hit hardest by the HIV epidemic. The HNSP covers the entire country, has a broader focus across federal departments and agencies beyond HHS and all sectors of society, and addresses the integration of several key components, including stigma, discrimination, and social determinants of health.

IN IT TO END IT: OUR PLAN TO END THE HIV EPIDEMIC

In 2019, the NFFRWP was one of just ten jurisdictions to be awarded HRSA funding to create a comprehensive, community-driven plan to end the local HIV epidemic. The development of this plan has been completed as a collaborative effort between the NHFFRWP and the Greater Hartford Ryan White Part A Program to respond to the area's growing incidence of HIV in MSM of color, Black women, and transgender women and men. The plan defines activities for six regions:

- **Region 1:** Greater New Haven
- **Region 2:** Waterbury/Meriden, and the Naugatuck Valley
- **Region 3:** Greater Bridgeport
- **Region 4:** Stamford-Norwalk
- **Region 5:** Greater Danbury County
- **Region 6:** Hartford

In It to End It: Our Plan to End the HIV Epidemic (IITEI) supports the U.S. Department of Health and Human Services "Ending the HIV Epidemic: A Plan for America" and has been formatted to align with the updated HIV National Strategic Plan (2021 to 2025). IITEI was initially conceived to be a five-year plan aligning with the timeline of the HNSP. However, with potential changes in funding appropriations and HRSA's announcement of a revised three-year funding cycle for Ryan White Part A Programs beginning in 2022, the plan's timeline was shortened to an initial two years.

LEADERSHIP TEAM

The initial planning strategy for IITEI was to have each of the six regions establish individual planning bodies and develop a localized plan. Overwhelmingly, the HIV community didn't want to establish these planning groups, citing the many planning bodies, task forces, and community groups already meeting and collaborating. Instead, a Leadership Team was established to provide guidance and feedback during each stage of the plan's development.

Leadership Team members:

- **New Haven:** Chris Cole, Co-Chair of New Haven/Fairfield Ryan White Part A Planning Council
- **New Haven:** Rick Radocchia, Director of Clinical Services, A Place to Nourish Your Health (APNH)
- **Waterbury, Meriden, and the Naugatuck Valley:** Sam Bowens, HIV Prevention Program, City of Waterbury Department of Public Health, member of Positive Prevention Connecticut
- **Bridgeport:** Nancy Kingwood, Deputy Director of HIV Services, GBAPP, Inc., and member of the Connecticut HIV Planning Consortium
- **Stamford/Norwalk:** Krystle Moore, Health Educator, Liberation Programs, and Chair of the Stamford/Norwalk Planning Body
- **Danbury:** Taylor Edelmann, Health Equity & Community Engagement Coordinator, APEX Community Care
- **Hartford:** DeLita Rose Daniels, City of Hartford Health Dept. of Health and Human Services, member of the Bristol Mayor's Task Force on AIDS

BRANDING THE INITIATIVE

To distinguish this initiative from other HIV planning activities in the jurisdiction, unique branding and messaging were developed. The branding was embraced by HIV stakeholders and quickly became a recognized name and logo. OurHIVPlan.org was created to promote the initiative and share the results of the community engagement sessions.

PRE-PLANNING ASSESSMENT

REVIEW OF OTHER ENDING THE HIV EPIDEMIC PLANS

Ending the HIV Epidemic plans from 25 jurisdictions were evaluated to inform engagement strategies, goals and activities, performance metrics, and content organization. This analysis was shared with the New Haven/Fairfield HIV Services Planning Council and community stakeholders to prepare them for the planning process.

REVIEW OF THE 2018 CONNECTICUT GETTING TO ZERO REPORT

The Connecticut HIV Planning Consortium established the Getting to Zero (G2Z) Commission to develop recommendations to respond to the growing number of new cases of HIV in men having sex with men (MSM) of color, Black women, and transgender women. Eighteen listening sessions were conducted in New Haven, Waterbury, Bridgeport, Stamford, and Hartford. More than 200 people participated. The 2018 Connecticut Getting to Zero Report details city-specific activities and six overarching recommendations.

G2Z City-Specific Feedback

New Haven

- Make HIV testing routine
- Increased awareness for PWH living longer, healthier lives
- Increased HIV education in the schools and community
- HIV marketing directed to areas with higher HIV rates
- Increased advocacy to decrease HIV stigma
- Incentives to patients for HIV testing
- Increased education and sensitivity from medical professionals

Waterbury

- Increased HIV education for medical professionals
- HIV and sex education in high school
- Patient feedback to doctors regarding their engagement with them
- Increased support and acceptance for PWH from the community and church
- Legislation to increase incentives for physicians to treat HIV
- Increased marketing for PrEP
- Forums and transgender groups to address specific needs of transgender women
- Providers who are transgender-affirming and knowledgeable about HIV
- Increased HIV advertising

Bridgeport

- Increased HIV education in homes, schools, and churches to reduce stigma
- Education within the gay community about HIV
- Expanded facility hours, including Saturdays
- Education and advocacy to address transphobia and lack of community support
- Increased education and sensitivity from medical professionals
- Increased HIV advertising

Stamford

- Increased education in schools and churches to address testing, care, and stigma
- Increased cohesion among the transgender community
- Increased HIV advertising
- Increased education and sensitivity from gender-affirming medical professionals
- Mentorship for younger transgender women

Hartford

- Increased dialogue in gay communities
- Increased community education in English and Spanish
- Increased HIV and sex education in the school system
- More globally positioned HIV campaigns that include Black women
- Legislation to increase incentives for physicians to treat HIV
- Marketing campaigns with empathy that target PWH

G2Z Recommendations

Recommendation 1: State-wide G2Z Implementation
Form a CT G2Z Working Group to develop an overall model for implementing recommendations of the 2018 CT G2Z Commission at the state level and to drive and monitor G2Z activities statewide. Engage leaders in the five highest HIV incidence cities (Hartford, New Haven, Bridgeport, Waterbury, and Stamford) to monitor G2Z activities at the city level.

Recommendation 2: G2Z Implementation in the Five Cities
Form a G2Z Working Group in each of the five highest HIV incidence cities (Hartford, New Haven, Bridgeport, Waterbury, Stamford) to implement G2Z recommendations in each city. Engage all stakeholders, including providers addressing HIV care and prevention, and community members most impacted by HIV, in the city G2Z Working Group and in implementation efforts.

Recommendation 3: PrEP and PEP Education and Implementation
Develop and launch a visible statewide PrEP and PEP education and implementation program. Engage the state-level and city-level G2Z Working Groups, primary care providers, and other healthcare providers, particularly those caring for people with substance use disorders, mental health needs, and sexually transmitted infections, in planning and implementation. PrEP and PEP promotional materials should be inclusive of all groups at high risk for HIV infection.

Recommendation 4: State-wide Multilevel HIV Educational Campaign and Provider Capacity Building Training
Under the direction of the CT G2Z Working Group, develop and implement multilevel and population-specific HIV education and training campaigns at the state and city levels to educate or reeducate providers and community members about HIV prevention, care, and stigma. Include training in current HIV medications and protocols and LGBT sensitivity/ awareness for providers; include U=U (undetectable = untransmittable) and peer education programming in the community.

Recommendation 5: Implementation of Routine HIV Testing
Engage stakeholders to develop HIV testing legislation in accordance with CDC recommendations for routine HIV testing for all persons aged 15-64. Enforce routine HIV testing legislation in all healthcare facilities statewide, with emphasis on primary care providers and substance abuse facilities. Develop marketing for routine testing for the general population.

Recommendation 6: Implementation of Standardized Medical Care for People with HIV
Close gaps in HIV treatment by implementing and enforcing best-practice medical care for PWH. Incentivize, track, and enforce providers' adherence to the most up-to-date medications and medical care protocols.

Source: Connecticut Getting to Zero Report

INTERVIEWS WITH LEADERS IN THE HIV COMMUNITY

Between April and October 2020, interviews were conducted with more than 25 HIV community leaders in each Region, representing PWH, local planning body leadership, HIV prevention and care program leads, pharmaceutical company representatives, leaders of community-based organizations, NHFFRWP staff, and others. Participants were asked to share their thoughts on the current HIV services in their Region, high-priority prevention and care service gaps, community engagement in HIV issues, opportunities for innovative service delivery (rapid start, self-test kit distribution, etc.), and policy issues.

Responses were analyzed and organized into common strategies.

- Comprehensively Address the Needs of Priority Populations
- Coordinate Planning Among Regions
- Diversify Funding
- Implement a Holistic Approach to Service Delivery
- Implement Media Initiatives
- Implement National Initiatives
- Improve Data Sharing and Use
- Improve the Quality of HIV Care
- Improve Relationships Among Stakeholders, Providers and Health Departments
- Increase the Number of Providers Offering LGBTQ+ Health Care/Increase Health Awareness Among LGBTQ+ Populations
- Increase HIV Education for Priority Populations, Providers, and the Public
- Increase the Number of HIV Providers
- Increase the Use of PrEP/PEP
- Modernize the System of Care
- Reignite Community Engagement in HIV Issues
- Revise HIV Policies

Of the 16 strategies identified by stakeholders, five align with the recommendations of the G2Z Report:

- Establishing region-specific HIV planning
- HIV education and training for providers
- PrEP/PEP education and expansion
- Policy initiatives to standardize routine HIV testing
- Statewide HIV media initiatives

ANALYSIS OF STAKEHOLDER-DEFINED STRENGTHS, WEAKNESSES, OPPORTUNITIES, AND THREATS (SWOT)

A SWOT analysis was completed for each of the strategies identified by HIV leaders.

Figure 3: Comprehensively Address the Needs of Priority Populations

STRENGTHS

- General agreement on priority populations (young MSM of color, women of color, transgender)
- Other populations discussed: Haitians, Africans, White IDU, Latin Americans, large older population getting diagnosed especially in BIPOC
- In-care clients have good viral suppression
- Monitoring older populations, homelessness among youth
- IDU incidence has been dramatically lowered

WEAKNESSES

- MSM tend to be younger
- Black MSM don't self-identify as MSM
- Transgender population tends to be less virally suppressed
- Lack of language-appropriate services
- Many in priority populations are low-literacy and underserved (?)
- Many clients with mental health issues
- Immigrants have never been tested, are presenting with AIDS and TB/PCP

OPPORTUNITIES

- Using non-HIV care services as a gateway to testing and PrEP/PEP
- Make PrEP more normative for the general public
- Increase non-HIV care and supportive services for LGBTQ communities to improve sexual health, HIV/STD testing, and linkage to care
- Expand routine, opt-out HIV testing as a standard part of medical care
- Focus less on HRSA/CDC-defined populations, evaluate micro-populations

THREATS

- Lack of involvement by Black and brown communities has caused a reversal of progress made in testing and care
- Black Men: "A population that we won't be able to engage" – who has a good answer on how to engage men on the down low?
- Young Black men start PrEP but are erratic, stop taking, or engage in risky behavior
- Cultural and racial barriers to be addressed

Figure 4: Coordinate Planning Among Regions

STRENGTHS

- Some Regions have formal planning groups
- Other Regions have monthly provider meetings or stakeholder meetings
- Dedication of Planning Council and Task Force members
- Some Regions are succeeding in engaging their communities

WEAKNESSES

- Task Forces are viewed as political, ineffective and problematic
- Current planning is not prescriptive enough
- Lack of focus, unclear why things are done a certain way, inconsistent statewide response
- Multiple planning bodies, task forces, committees, but questionable accountability
- Providing data can lead to more requests for other data, rather than an evaluation of what was provided
- Same Task Force and Planning Council members year-after-year. No PLWH leadership development

OPPORTUNITIES

- Align planning and service delivery more effectively
- Region-specific, prescriptive planning – SMART goals, specific goals and activities
- Identify data needs
- Make planning bodies accessible to PLWH
- New methods of stakeholder engagement, change the conversations
- Bring transgender people to the table

THREATS

- Data requests can be challenged by small population sizes, data security, etc.
- Task force and planning meetings can exclude stakeholder involvement
- Bridgeport Health Department is not engaged/may have lost funding?
- "Politics get in the way"
- Unclear roles, authority, effectiveness of task forces in the modern era

Figure 5: Diversify Funding

STRENGTHS

- Waterbury has access to resources and provides comprehensive services
- New Haven funding is being spent down
- Some organizations may not have funding issues due to grants from the state health department, federal programs, etc.

WEAKNESSES

- With cuts in Part B funding, more clients will move to Part A
- Funding aligns with Region size, not Region need
- Providers have expectations that they will get refunded regardless of performance, because they've been funding for many years

OPPORTUNITIES

- Begin sustainability planning
- Billing capacity/service delivery evaluations for providers to access feasibility of realigning services/bundling services for billing opportunities
- Global funding strategy, rather than siloed programmatic funding
- Less reliance on percentage-based funding?

THREATS

- Lots of unfunded mandates
- People who are worried about their funding won't speak their mind
- No State funding for HIV services
- At least one Region can't spend funding

Figure 6: Implement a Holistic Approach to HIV Service Delivery

STRENGTHS

- Good CADAP formulary
- Access to meds not an issue
- Syringe Exchange Programs have resulted in a huge drop in IDU cases
- Intensive case management system
- Prevention Program is well run

WEAKNESSES

- Rapid Start: Providers want to use med samples to start, but organizations have rules prohibiting accepting pharma samples
- Housing: Wait list is years long, available housing can be far away
- Mental Health and Substance Use clients missing appointments
- Health department and CBO reflectiveness of population, especially in leadership and community-facing roles
- Difficult to get undocumented clients approved for referrals for specialists
- Too many people outside of priority populations are tested, not targeting at-risk people well

OPPORTUNITIES

- Expanding Rapid Start, defining a jurisdictional RS timeframe
- Telehealth expansion: Chronic no-shows are lower and viral suppression has improved
- Create opportunities for community and organizational leadership development
- Getting clients in medical care, employment and housing – clients want to work and move forward with life
- Improved linkage to care for Out of Care clients

THREATS

- Large burden on Case Managers to meet clients needs
- Need for housing, jobs, services will increase due to Covid-19
- Increasing the FPL for services would decrease services overall
- Disconnected service delivery: need greater informed and compassion care, treat people like customers rather than clients
- The impact of future funding decisions being made without consideration or notification of other funding entities

Figure 7: Implement Media Initiatives

STRENGTHS

- Some health departments and organizations have a social media presence
- State Health Department has signed on to U=U, and the Positive Prevention Group has been developing campaigns
- State Health Department is currently comfortable discussing sex, sexuality, SSPs, etc.

WEAKNESSES

- No U=U messaging in the community
- Clients are uncomfortable with U=U. They get mixed messaging from providers, unsure of what to believe
- No stand-alone website for CT HIV resources. Current information is outdated and varies by organization

OPPORTUNITIES

- Social media/marketing can be highly targeted to priority populations
- Increase provider/CBO capacity for social media
- Develop consistent U=U messaging for providers statewide
- Provider training on U=U
- Promotion of U=U to PWH

THREATS

- Potential costs
- Who has control over messaging?

Figure 8: Implement National Initiatives

STRENGTHS

- People believe they have innovative ideas that could be implemented
- Consistently discussed: Rapid Start, home HIV test kits, routine opt-out testing, use of social media, trauma-informed care, New York project to rapidly engage clients in care, qualify them for housing and other programs
- Home Test Kit pilot was started just before Covid-19. Agencies are creating protocols, combining with tele-health
- Have the technology and ability to do home test kits

WEAKNESSES

- National initiatives not really known in the HIV community
- "Prevention program does these things"
- Medical providers may not have direct community involvement, aren't looking past their service delivery, don't see how they can be involved

OPPORTUNITIES

- Share national initiatives with the community (social media, presentations, flyers, success stories, etc.)
- Implement national initiatives from a business perspective – offering increased customer service to clients and the community
- Focus on U=U and home test kits
- Specific training on national initiatives (webinars hosted by planning council?)

THREATS

- Not much funding for unique initiatives
- Community knowledge needs to ramp up before initiatives can be implemented

Figure 9: Improve Data Sharing and Use

STRENGTHS

- Extensive data collection from State Health Department and RW Programs

WEAKNESSES

- Agencies want CareWare training to get everyone at the same proficiency
- Providers have challenges entering data in the right contract
- Usually don't get detailed data from the State Health Department because the client numbers are so small - easily identifiable
- Need a better working relationship with the health department colleagues as to getting the data to the providers in a timely way and efficient manner

OPPORTUNITIES

- Comprehensive CareWare training, and Train-the-Trainer opportunities
- Work with the State Health Department to determine how to get useful targeted data
- Training on how to evaluate data for decision-making for Planning Council members and stakeholder participants

THREATS

- How to plan without geo-specific data due to privacy

Figure 10: Improve the Quality of HIV Care

STRENGTHS

- Regional quality improvement groups/committees
- Recent assessment of priority populations
- Performance measures seem to have improved viral suppression rates
- Connecticut has about 8% to 10% out of care
- Providers attempting to expand HIV testing and PrEP services with community partners
- Every Region has PDSAs to work on, and quality improvement goals

WEAKNESSES

- No Ryan White or CDC-sponsored trainings, nor requested trainings to address community-identified needs
- Linkage to care timeline of 90 days
- Clients are not as treatment adherent to PrEP as hoped

OPPORTUNITIES

- Involve private providers in Quality initiatives, including Rapid Start and viral suppression

THREATS

- Reluctance of private providers to share quality data for comparison

Figure 11: Improve Relationships Among Stakeholders, Providers and Health Departments

STRENGTHS

- Good relationships, same contract managers for years, strong relationships and respect, Part B too even though there's a cut
- State Health Department prefers to support communities to take the lead on initiatives

WEAKNESSES

- Some entities don't refer to Yale clinics, not culturally competent or compassionate
- Yale is a bureaucratic nightmare, works for underserved clients, clinical and non-welcoming
- Rivalry/challenge with Yale
- State Health Department: The way they collaborate with other RW funding recipients - took a long time to share info - cut funding for service categories that they don't fund, their funding cuts affect our clients, and they weren't very transparent (sent letters without informing anyone)

OPPORTUNITIES

- Facilitated work to overcome organizational biases

THREATS

- Unwillingness to refer clients is hindering client choice and potentially contributing to poorer health outcomes

Figure 12: Increase Health Awareness Among LGBTQ+ Populations and Increase and the Number of Providers Offering LGBTQ+ Health Care

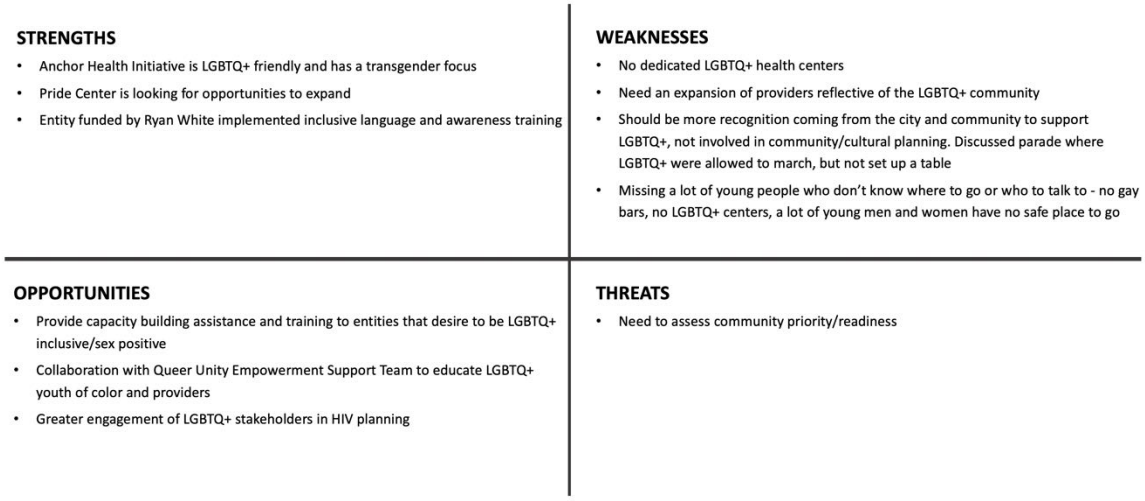


Figure 13: Increase HIV Education for Priority Populations, Providers, and the Public

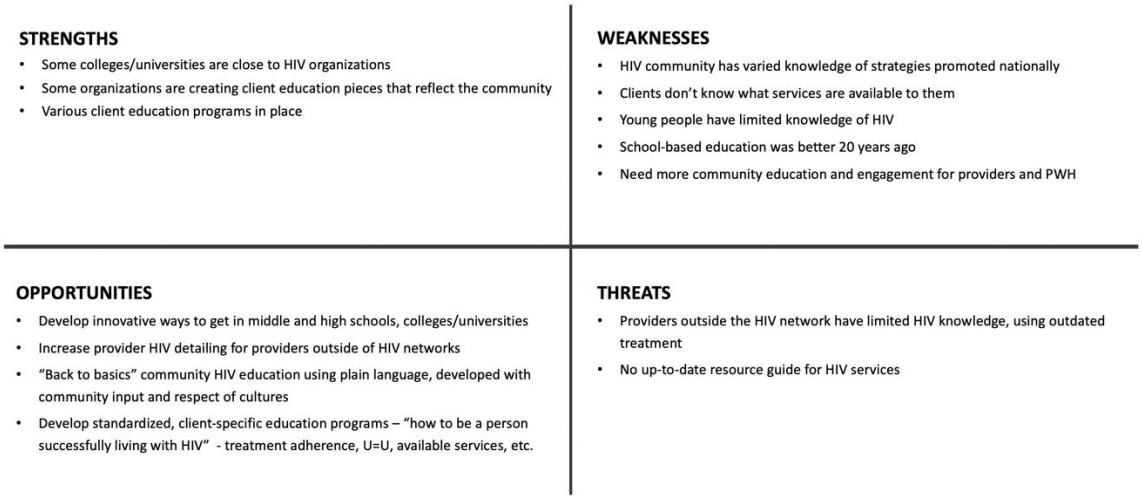


Figure 14: Increase the Number of HIV Providers

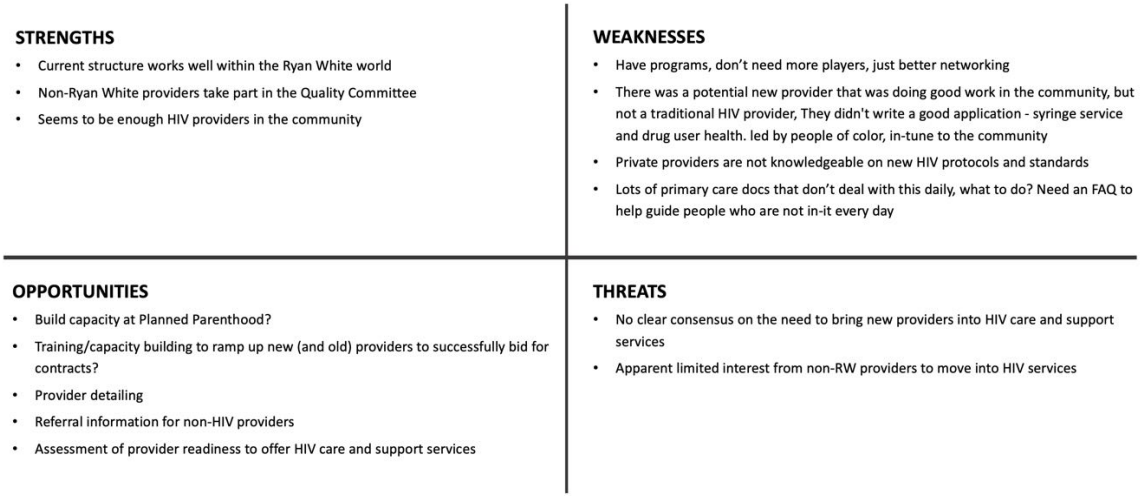


Figure 15: Increase the Use of Pre-Exposure Prophylaxis (Prep) and Post-Exposure Prophylaxis (Pep)

STRENGTHS

- Yale is funded for testing, PrEP/PEP, other prevention initiatives
- HIV Community seems to be onboard with PrEP/PEP
- Everyone who gets funded for prevention work had to incorporate some component of PrEP/PEP in their services
- Planned Parenthood has been a PrEP champion

WEAKNESSES

- Non-profits that don't offer clinical services haven't transitioned to PrEP/PEP well
- PrEP uptake is low. No real hub for LGBTQ health. No obvious place to drive people to
- Young Black and Hispanic MSM start PrEP, but are erratically engaged, involved in risky behavior

OPPORTUNITIES

- Social media/marketing
- Increase PrEP referrals from HIV testing entities
- Lots of PrEP knowledge comes from peers – develop opportunities for peer-led education programs
- Promote PrEP compliance, navigation services
- Complete PrEP/PEP detailing with hospitals and medical providers

THREATS

- Not much funding for unique initiatives
- Community knowledge needs to ramp up before initiatives can be implemented
- Historic cultural resistance to medical care/medication

Figure 16: Modernize the System of Care

STRENGTHS

- Not a lot of change in the current mix of service providers/system of care
- Staff positions generally reflective of the community
- Regions have good relationships with each other
- Region 1 has a good number of service providers, transportation, clients can generally get the care they need
- Regions 2 has heavy involvement with faith community, supportive of LGBTQ+ community

WEAKNESSES

- Not a lot of change in the current mix of service providers/system of care
- Leadership, management, board positions not reflective of the communities served
- State health department may not communicate well, transparency issues
- How do we get people to work together more?
- Services need to adapt and modernize. "I can't use my clinical skills from 25 years ago – why are we allowing outdated service delivery
- Until recently, not much innovation or change in services/delivery

OPPORTUNITIES

- Opportunity to comprehensively monitor and revitalize service delivery
- Focus on the community as a whole
- Satellite services?
- Covid-19 has shown we can innovate and be successful

THREATS

- The upheaval needed for change won't be received well
- West Haven clients need to go to New Haven for care
- No change in service provider mix for some time
- Not a lot of providers are offering targeted services to high-priority populations

Figure 17: Reignite Community Engagement in HIV Issues

STRENGTHS

- Planning Council seems responsive to community needs
- There are stakeholders who are activists, going to Alderman's meetings, protesting, etc.
- Waterbury has great rapport with faith-based communities

WEAKNESSES

- People get engaged, stay around for a bit, the leave
- Pharma reps and others can get PWH to meetings, but the meetings are at night, and it takes a lot of work to ensure PWH come
- Community awareness of HIV is so-so
- New leaders aren't from the communities they serve
- Stamford is a commuter town – no one stays (is active) in the community – they just live there

OPPORTUNITIES

- Social media/marketing to reignite community conversations about HIV
- Activate youth in social issues, get them involved with an HIV perspective
- Stigma reduction activities

THREATS

- Community awareness of HIV is so-so
- Community desire to become involved in HIV activities seems low
- Little engagement in HIV work by non-HIV providers/organizations (if you're not funded to do the work, you're not involved)
- HIV/Non-HIV services in some regions are very siloed

Figure 18: Revise HIV Policies

DEMOGRAPHIC ANALYSIS OF OUT OF CARE/LOST TO CARE CLIENTS, BY ZIP CODE

In 2020, The NHFFRWP completed an analysis of state data by zip code and high prevalence rates in each of the EMA's regions to enhance Ending the HIV Epidemic efforts. Activities included:

- Conducting a regional analysis based on state epidemiology reports to determine areas with high rates of HIV prevalence and zip codes where clusters are reported.
- Using zip code and cluster data to determine next steps in engaging out of care/lost to care clients (Clients in "the Gap") with the NHFFRWP Intensive Case Managers in the EMA.
- Compiling and analyzing data to identify opportunities for improvements in linkage and engagement.

Definitions

- **In Care:** One or more medical visits in 12 months; One visit defined as a CD4, viral load, or genotype test result during the evaluation period.
- **Virally Suppressed:** 200 copies/mL or less
- **Gap:** PWH who are in medical care but not virally suppressed.

Priority Zip Codes for Outreach to Out of Care/Lost to Care Clients

- **Region 2 (Waterbury, Meriden, and the Naugatuck Valley):** 06704, 06705
- **Region 4 (Stamford-Norwalk**): 06902, 06854
- **Region 5 (Greater Danbury County):** 06810, 06811

Recommendations

- **Improve reengagement in HIV care:** Investigate the current system with Ryan White-funded Medical Case Managers (MCM) and Intensive Case Managers (ICM). Evaluate the processes and procedures in place to collaborate with Disease Investigation Specialists (DIS)workers for the list of out-of-care patients.
- **Improve retention in HIV Care:** Develop a workgroup among the five (5) Regions for ICM teams to discuss and share strategies for offering home- and field-based patient navigation services. This workgroup, along with DIS, would pilot specific strategies in each Region based on activities that have been proven successful among the populations that are most likely out of care or at risk of becoming out of care. The workgroup within the EMA would offer a venue to bring in other programs to enhance training opportunities, increase strategy development, and improve overall outreach to clients.

Source: Demographic Analysis by Zip Code to Enhance the New Haven-Fairfield Counties EMA Efforts in Getting to Zero, Report for the New Haven Ryan White Part A Program, Germaine Solutions

REVIEW OF THE RYAN WHITE PROGRAM'S CONTINUOUS QUALITY IMPROVEMENT GOALS

Goal 1: Increase linkage to HIV care in newly diagnosed persons.
Objective: Increase linkage to HIV care in newly diagnosed persons from 64% to 75%.

Goal 2: Improve health outcomes for PWH.
Objective: By the end of FY2020, increase viral load suppression among persons in HIV medical care from 90% to 93%.

Goal 3: Reduce HIV-related disparities and health inequities.
Objective 1: By the end of FY2020, increase viral load suppression among black women, transgender women of color, and young MSM of color by 5%.

Objective 2: In FY2020, at least 90% of clients receiving medical case management services are actively engaged in medical care as documented by at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.

Goal 4: Achieve a more coordinated statewide response to the HIV epidemic.
Objective: Strengthen collaboration between HIV prevention and care partners.

COMMUNITY ENGAGEMENT

the G2Z Commission engaged more the 200 PWH and others to develop the 2018 (G2Z) report. Rather than duplicate this effort, a complimentary engagement strategy was established to inform IITEI.

Stakeholders were divided into two groups:

- PWH and the Community
- Planning Bodies, Task Forces, and Providers

Due to social distancing mandates implemented in response to the Covid-19 pandemic, all community engagement sessions were conducted online using the Zoom virtual meeting platform.

INPUT FROM PWH AND THE COMMUNITY
Participants in this group included:

- PWH who were not members of a planning body, task force, or staff at an agency
- People at risk of acquiring HIV
- Affected community members
- Black faith leaders and members of the Black faith community

Because the 2018 G2Z initiative had used a relatively formal focus group structure for community engagement, feedback sessions for IITEI were designed to be small and informal. Participants were asked to share their thoughts and perceptions on sexual health, accessing services, and what they thought could be done to end the HIV epidemic in their communities. More than 60 people participated in these robust conversations.

During the discussions, graphic recorders created visualizations of the stories, themes, and comments. The final discussion boards provide a captivating record of each engagement session, conveying emotion and intent better than a written report can. Participants see their words come to life, and those viewing the boards have a greater sense of the tone and content of the meeting. The discussion boards can be displayed during later meetings for reference, shared online, and provided to participants as a souvenir of the session.

Figure 19: 12.15.20 Support Group for PWH Aged 50 and Older

Discussion Highlights

- Ryan White Programs provide access to medical care and relief from the financial burden of medical care costs. "We're here today because of Ryan White."
- The amount of paperwork and documentation needed to enroll in Ryan White and other programs is overwhelming. Continually having to provide you need and qualify for services is demeaning.
- PWH want to be more involved in educating the community about HIV. To help reduce stigma and discrimination, several PWH stated that they would be willing to share their HIV status publicly to demonstrate they are living healthy and well with HIV.
- Participants shared that they wanted to help other PWH, but agencies wouldn't hire them because they didn't have relevant experience and skills.
- Participants shared they felt some agency staff are not qualified for their positions. There is a need for additional training for staff at community-based organizations.
- Long-term survivors shared that in the initial years of their diagnosis, they stopped working to manage their HIV. Now, they felt well enough to work, but their professional skills were no longer relevant.

Figure 20: 12.02.20 Chat for Change Group

Discussion Highlights

- Many people think sexual health is just HIV/STI testing rather than physical/emotional/mental well-being related to sex and sexuality.
- Many participants learn about sexual health from friends and sexual partners.
- Some people are hesitant to get tested because of actual or perceived costs, lack of knowledge about HIV, and misconceptions about the testing experience.
- There needs to be better sex education in schools.
- Participants shared they would not participate in an HIV-specific presentation or event, citing concern about others seeing them and spreading rumors. Instead, messaging should be incorporated into other things they already take part in. For example, an event could be sponsored by a health department testing program, with messaging woven into the experience. Pre-Exposure Prophylaxis (PrEP) could be discussed after a Tik Tok makeup tutorial.

Figure 21: 01.06.21 Transgender Youth Group

Discussion Highlights

- Instead of emphasizing safe practices and good choices, medical providers often focus on identifying how people have sex and their sexual partners.
- Participants discussed a range of informal ways they learned about HIV (movies, Tumblr, etc.) because there was no formal instruction in school.
- There are a variety of challenges to accessing quality, respectful transgender health care.
- PrEP is "like birth control for HIV."
- Transgender individuals are often portrayed as sad and serious. HIV prevention and care messaging for transgender people should be positive and uplifting.
- Participants shared they felt disconnected from older transgender individuals. They wanted better communication and mentoring opportunities from older peers in the community.

Figure 22: 01.25.21 MPowerment Group

Discussion Highlights

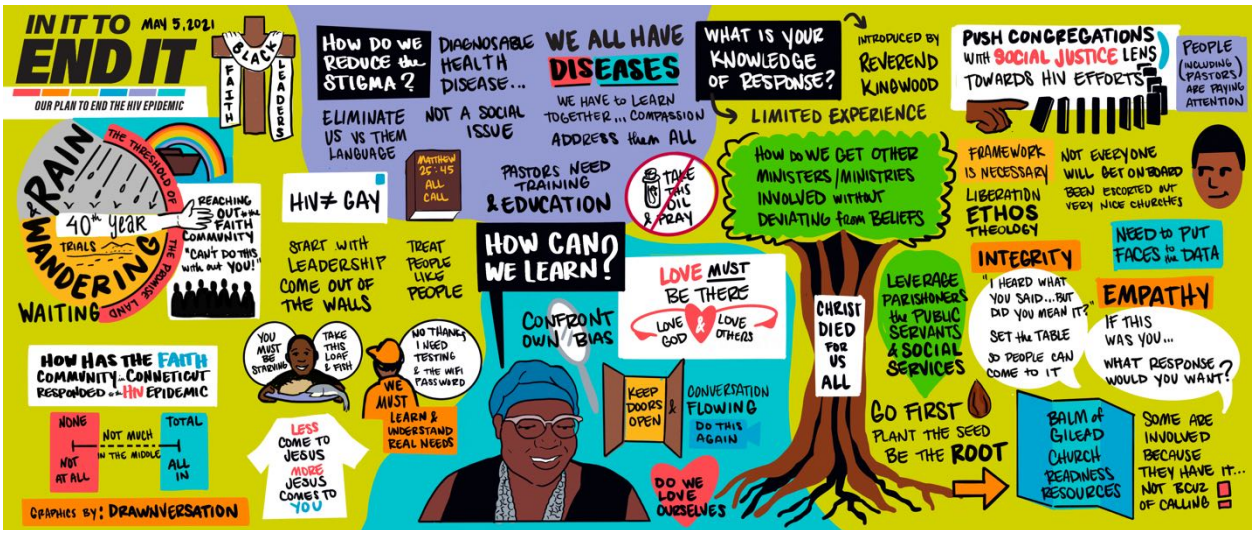
- HIV prejudices, stigmas, and myths still exist, especially among young MSM.
- People seem to have good knowledge of PrEP but don't know how accessible PrEP is. They are worried they will spend a lot of money.
- "People don't want to learn about HIV because if they did, they'd feel guilty about the choices they're making."
- Conversations about gay sex and sexuality aren't occurring with medical providers unless the provider has been identified as queer-friendly.
- Sex education in schools needs to more comprehensive and inclusive of different types of gender and sexuality.
- Dating apps need to be more committed to HIV/STI prevention and care.

Figure 23: 01.28.21 Clients of Mid-Fairfield AIDS Project (MFAP)

Discussion Highlights

- People are still uninformed about HIV. Traditional myths and perceptions are still discussed.
- There is little discussion of HIV in high school sex education classes.
- HIV prevention messaging must be tailored to each priority population.
- "Care" is physical, mental, and emotional. Many people living with HIV have faced trauma and haven't dealt with it. This makes it hard for people to get care or stay in care.
- Service providers are doing a great job!

Figure 24: 05.07.21 Black Faith Leaders



Discussion Highlights

- "We all have dis-eases. We must learn together and have compassion to address them all."
- Many pastors have limited HIV knowledge and experience dealing with HIV issues.
- Eliminate "us (people of faith) versus them (people with HIV)" mindsets.
- Use a social justice framework to push congregations to address HIV.
- Faith leaders can learn by confronting their own biases, keeping conversations flowing, and demonstrating empathy and integrity.
- The types of assistance congregations want to provide to the community aren't always what the community needs or wants.

Figure 25: 05.07.21 Members of the Black Faith Community

Discussion Highlights

- Participants felt they had little knowledge about HIV and its impact on the Black community. Because of this, their discussion focused on asking questions they had about HIV and how other faith communities have responded to addressing HIV in their communities.
- Faith leaders need to create safe spaces to talk about sexual expression and intimacy.

INPUT FROM PLANNING BODIES, TASK FORCES, AND PROVIDERS

Participants in this group included:

- Staff of community-based organizations providing HIV prevention and care services
- Staff of state and local HIV/STD/Hep-C public health programs (care and prevention programs)
- Staff of HIV/STD testing centers
- Members of planning councils, task forces, and other local HIV planning bodies or community groups
- HIV medical providers
- Elected and non-elected community leaders

The engagement strategy for IITEI was designed to gather feedback from people who often have little to no direct input in HIV planning. Community-based organizations and health programs were asked to have their entire staff take part and share their passion, knowledge, and expertise. Perhaps for the first time, front desk personnel, case managers, bookkeepers, and others not involved in face-to-face service delivery had a voice in HIV planning. Between November 2020 March 2021, more than 115 individuals participated in a facilitated activity to answer a single, straightforward question:

"What needs to happen in the next two to five years that will result in the end of the HIV epidemic in Connecticut?"

Participants generated ideas using a combination of individual brainstorming, two-member team review, and large group discussion. They then grouped these ideas based on common themes. Finally, they named specific strategies based on these groupings. The result of each session was a unique range of strategies and activities that would contribute to ending the HIV epidemic.

Participating Entities

Health Departments, Ryan White-Funded Providers, and Community-Based Organizations

- 11.30.20: Family Centers
- 12.11.20: Waterbury Health Department
- 12.17.20: APEX Community Care
- 01.06.21: Greater Bridgeport AIDS Prevention Program (GBAPP)
- 01.13.21: Mid-Fairfield AIDS Project (MFAP)
- 01.21.21: Liberation Programs
- 02.02.21: APNH Staff

Planning Bodies and Task Forces

- 12.08.20: New Haven Mayor's Task Force on AIDS
- 12.14.20: Positive Prevention Connecticut (the statewide prevention planning group)
- 02.03.21: Greater Hartford Ryan White Part A Planning Council
- 02.25.21: Bristol Mayor's Task Force on AIDS
- Various Meetings: New Haven/Fairfield HIV Services Planning Council

Outcome

More than 347 ideas were shared. These ideas were grouped and organized into 25 strategies. The complete listing of strategies and idea groups can be viewed in Appendix 1.

Strategies Identified During Engagement Sessions

HIV Testing (53 Ideas)
Education (52 Ideas)
Policy Revisions (40 Ideas, includes policy-related mentions from other strategies)
Access To Care (35 Ideas)
Innovation (32 Ideas)
Systems Improvements (27 Ideas)
Pre-Exposure Prophylaxis (Prep) (26 Ideas)
Stigma Reduction (26 Ideas)
Client-Centered Activities (25 Ideas)
Community Connection (23 Ideas)
Media Initiatives (23 Ideas)
Collaboration (20 Ideas)
Peer Mentoring (17 Ideas)
Funding (13 Ideas)
Undetectable=Untransmittable (13 Ideas)
Outreach (11 Ideas)
Vaccine/Cure (11 Ideas)
Condoms (10 Ideas)
Health Literacy (9 Ideas)
Housing (8 Ideas)
Provider Education (8 Ideas)
SSPs & Harm Reduction (8 Ideas)
Collaboration With the Faith Community (7 Ideas)
Address HIV Like Covid (5 Ideas)
Research (2 Ideas)

Visit OurHIVPlan.org to review the unique strategies and ideas of each participating entity, organized by Region.

ANALYSIS

Input from each engagement group was organized by strategy. Then, each group's priority for a strategy was determined based on the amount of discussion and ideas presented.

Figure 26: Prioritization of Strategies by Engagement Group

Strategy	PWH and the Community	HIV Leaders	Planning Bodies, Task Forces, and Providers	2018 G2Z Report
Access to Care	High	High	High	High
Client-Centered Initiatives/Priority Populations	High	High	High	High
Collaboration/Relationships		Moderate	Moderate	High
Community Connection/Planning	Moderate	High	Moderate	High
Condoms			Moderate	
Education (Sex Ed Reform, Community HIV Education)	High	Moderate	High	High
Faith Community: Collaboration and Action	High		Low	Moderate
Funding		Moderate	Moderate	
Health Literacy			Low	
HIV Like Covid			Low	
HIV Testing	High		High	High
Housing			Low	Low
Innovation		Moderate	High	
LGBTQ+ Health Access and Provider Knowledge	Moderate	Moderate		Moderate
Media Initiatives	Moderate	High	Moderate	High
Outreach	Moderate		Moderate	
Peer Mentoring	Low		Moderate	
Policy Revision		Low	High	Moderate
PrEP	Moderate	High	High	High
Provider Education	High	Moderate	Low	High
Research	Low		Low	
SSP/Harm Reduction			Low	
Stigma Reduction	High		High	High

Systems Improvement/Data Collection & Use	Moderate	High	High	Moderate
Undetectable=Untransmittable	Moderate	High	Moderate	Moderate
Vaccine/Cure	Low		Moderate	

Development of Strategies and Activities

After ranking the priorities of each engagement group, commonalities were identified. Then, discussion topics, comments, and ideas generated by each group were analyzed to develop the framework for each strategy. Goals, activities, lead entities, and performance metrics were then defined.

The final goals, strategies, and activities for IITEI were approved by the Leadership Team and NHFFRWP on June 23, 2021.

IN IT TO END IT: OUR PLAN TO END THE HIV EPIDEMIC

Definitions Used in This Plan

- **Goals:** Broad aspirations that enable a plan's vision to be realized
- **Objectives:** Changes, outcomes, and impact a plan is trying to achieve
- **Strategies:** Choices about how best to accomplish objectives
- **Activities:** Specific steps that will take place to implement the strategies and achieve the plan's goals
- **Performance Metrics:** Measurable data used to track progress, successes, and challenges

Implementation Timeline

- **Pre-Planning and Preparation:** July 1, 2021, to February 28, 2022
- **Year 1:** March 1, 2022, to February 28, 2023
- **Year 2:** March 1, 2023, to February 29, 2024

GOAL 1: PREVENT NEW HIV INFECTIONS

Objectives

- Increase awareness of HIV
- Increase knowledge of HIV status
- Expand and improve implementation of effective prevention interventions, including treatment as prevention, PrEP, PEP, and SSPs, and develop new options
- Increase the capacity of health care delivery systems, public health, and the health workforce to prevent and diagnose HIV

Strategies for Implementation by the New Haven/Fairfield Ryan White Program

Strategy 1.1	**Adopt the Status Neutral Prevention and Treatment Cycle (SNPTC) as the EMA's framework for rapid linkage to HIV, hepatitis, and STI care, or PrEP/PEP initiation (see Appendix 2 for a description of this framework).**	
Year 1	**Activity**	Collaborate with community partners to align prevention and care services to support the SNPTC as an EMA-wide framework.
	Lead Entities	New Haven/Fairfield Ryan White Part A Program, Greater Hartford Ryan White Part A Program, Connecticut State Department of Health HIV Prevention and Care Programs
	Performance Metric	Implementation evaluation completed. Year 2 SNPTC transition plan created.
Year 2	**Activity**	Execute the transition plan and establish SNPTC in the EMA.

	Lead Entities	New Haven/Fairfield Ryan White Part A Program, Greater Hartford Ryan White Part A Program, Connecticut State Department of Health HIV Prevention and Care Programs
	Performance Metric	SNPTC established by February 29, 2024.

Strategy 1.2	**Implement an Undetectable=Untransmittable (U=U) educational initiative for Ryan White clients.**	
Year 1	**Activity**	Collaborate with community stakeholders to inform the development and implementation of an educational initiative promoting HIV viral suppression as high-impact HIV prevention (U=U) to Ryan White clients.
	Lead Entities	New Haven/Fairfield Ryan White Part A Program, Greater Hartford Ryan White Part A Program
	Performance Metric	Campaign implementation and evaluation completed.
Year 1	**Activity**	Collaborate with other HIV Prevention and Care Programs to integrate U=U messaging into media initiatives, educational materials, and other consumer-centric activities. Add annual U=U client education to the monitoring tools for Medical Case Management and Outpatient Ambulatory Health Care.
	Lead Entities	New Haven/Fairfield Ryan White Part A Program, Greater Hartford Ryan White Part A Program, Connecticut State Department of Health HIV Prevention and Care Programs
	Performance Metric	U=U messaging is a standardized component of all HIV prevention and care media and materials.

Recommended Strategies for Community Implementation

Strategy 1.3	**Complete detailing activities to increase the number of medical providers offering PrEP and PEP services in geographic areas with high HIV incidence.**	
Year 1	**Activity**	Complete at least five PrEP/PEP detailing sessions with medical providers offering services in geographic areas with high incidence of HIV.
	Recommended Lead Entity	Connecticut State Department of Health HIV Prevention Program
	Performance Metric	At least five detailing sessions are completed by February 28, 2023.

Year 2	**Activity**	Complete at least five PrEP/PEP detailing sessions with medical providers offering services within geographic areas with high incidence of HIV.
	Recommended Lead Entity	Connecticut State Department of Health HIV Prevention Program
	Performance Metric	At least five detailing sessions are completed by February 29, 2024.

Strategy 1.4	**Increase the number of entities providing HIV, hepatitis, and STI testing in geographic areas of high HIV incidence, including non-traditional partners such as walk-in labs, pharmacies, and mobile testing services.**	
Year 1	**Activity**	Recruit at least five new entities to provide HIV, hepatitis, and STI testing within geographic areas with high incidence of HIV.
	Recommended Lead Entity	Connecticut State Department of Health HIV Prevention Program
	Performance Metric	At least five new entities are providing HIV, hepatitis, and STI testing services by February 28, 2023.
Year 2	**Activity**	Recruit at least five new entities to provide HIV, hepatitis, and STI testing within geographic areas with high incidence of HIV.
	Recommended Lead Entity	Connecticut State Department of Health HIV Prevention Program
	Performance Metric	At least five detailing sessions are completed by February 29, 2024.

Strategy 1.5	**Develop and implement a community-informed PrEP/PEP media initiative, with specific messaging for young Black and Hispanic MSM, Transgender women and men, and Black women.**	
Planning & Preparation	**Activity**	Collaborate with community stakeholders to inform the development and implementation of a PrEP/PEP media campaign.
	Recommended Lead Entity	Connecticut State Department of Health HIV Prevention Program
	Performance Metric	At least two community listening sessions are presented.

Year 1	**Activity**	Develop and implement a PrEP/PEP media campaign using traditional and digital formats. Develop relationships with local influencers, community leaders, and other partners to support messaging on digital platforms. Create and distribute a social media tool kit to community organizations. Establish a performance monitoring and evaluation plan.
	Recommended Lead Entity	Connecticut State Department of Health HIV Prevention Program
	Performance Metric	Presentation of the media campaign. Social media tool kit produced and distributed to community organizations. Campaign performance is assessed using the performance and monitoring plan.
Year 2	**Activity**	Collaborate with community stakeholders to evaluate the Year 1 campaign. Make revisions as needed and continue the campaign in Year 2.
	Recommended Lead Entity	Connecticut State Department of Health HIV Prevention Program
	Performance Metric	Presentation of the Year 2 media campaign. Campaign performance assessed using the performance and monitoring plan.

GOAL 2: IMPROVE HIV-RELATED HEALTH OUTCOMES OF PEOPLE WITH HIV

Objectives

- Link people to medical care immediately after their HIV diagnosis and provide low-barrier access to HIV treatment
- Identify, engage, or reengage PWH who are not in care or not virally suppressed
- Increase retention in care and adherence to HIV treatment to achieve and maintain long-term viral suppression
- Increase the capacity of health care delivery systems, public health, and the health workforce to serve PWH

Strategies for Implementation by the New Haven/Fairfield Ryan White Program

Strategy 2.1	**The NHFFRWP will establish a rapid linkage to care protocol as a required component of service delivery. This protocol will link all newly diagnosed PWH, or those who were previously diagnosed and returning to care, to their first medical appointment within seven days of identification.**	
Planning & Preparation	**Activity**	Collaborate with Ryan White-funded providers to identify existing linkage to care efforts and establish a framework for rapid linkage to care using a multi-disciplinary approach (intensive case management, peer and faith support, mental health treatment, etc.).
	Lead Entity	New Haven/Fairfield Ryan White Part A Program

	Performance Metric	Creation of the service delivery framework for rapid linkage to care.
Planning & Preparation	**Activity**	Create a service delivery model for inclusion in Year 1 Ryan White Part A contracts, including standards of care and quality indicators.
	Lead Entity	New Haven/Fairfield Ryan White Part A Program
	Performance Metric	Service delivery model created by December 2021.
Year 1	**Activity**	Release Outpatient Ambulatory Medical Care (OAMC) contracts with mandated rapid linkage to care components.
	Lead Entity	New Haven/Fairfield Ryan White Part A Program
	Performance Metric	OAMC contracts include rapid linkage to care components.

Strategy 2.2	**Develop and implement a pilot program to adapt the Contingency Management model used in substance use services to HIV care (provision of motivational incentives and tangible rewards to PWH who are erratically engaged in care).**	
Year 1	**Activity**	Collaborate with substance use programs to evaluate and adapt the Contingency Management model to improve retention in HIV care and viral suppression among PWH who are erratically in care.
	Lead Entity	New Haven/Fairfield Ryan White Part A Program
	Performance Metric	Community-informed adaptation of the Contingency Management Model to HIV retention and care services.
Year 1	**Activity**	Development of a pilot project to assess adaptability and effectiveness.
	Lead Entity	New Haven/Fairfield Ryan White Part A Program
	Performance Metric	Pilot project initiated by February 28, 2023.
Year 2	**Activity**	Based on the pilot's success, incorporate service delivery into the continuum of NHFFRWP services.
	Lead Entity	New Haven/Fairfield Ryan White Part A Program
	Performance Metric	HIV Contingency Management model established as a contracted service.

Strategy 2.3	Develop and implement a jurisdiction-wide presentation series to promote best practices in HIV care and prevention and ignite conversation about local issues that impede progress toward ending the local HIV epidemic.	
Year 1	**Activity**	Host a community-informed presentation series. Sessions will focus on personal growth, professional development, and leadership; innovations in service delivery; and addressing diversity, inclusivity, and health disparities of PWH.
	Lead Entity	New Haven/Fairfield Ryan White Part A Program
	Performance Metric	Completed presentation series.
Year 2	**Activity**	Based on community response, host a second community-informed presentation series.
	Lead Entity	New Haven/Fairfield Ryan White Part A Program
	Performance Metric	Completed presentation series.

Strategy 2.4	Complete detailing sessions to increase provider knowledge of the availability of Ryan White-funded medical care, supportive services, and linkage to care systems.	
Year 1	**Activity**	Complete at least five detailing sessions with medical providers that are not funded by the Ryan White Part A Program.
	Lead Entity	New Haven/Fairfield Ryan White Part A Program
	Performance Metric	At least five detailing sessions completed by February 28, 2023.
Year 2	**Activity**	Complete at least five detailing sessions with medical providers that are not funded by the Ryan White Part A Program.
	Lead Entity	New Haven/Fairfield Ryan White Part A Program
	Performance Metric	At least five detailing sessions completed by February 29, 2024.

Recommended Strategies for Community Implementation

Strategy 2.5	**Train medical providers to expand their ability to offer high-quality, affirming, and sex-positive medical care to LGBTQ+ people, including PrEP/PEP services and HIV, hepatitis and STI testing and treatment.**	
Year 1	**Activity**	Present at least two trainings to increase provider competency to offer affirming, sex-positive medical care to LGBTQ+ people.
	Lead Entity	Connecticut Department of Health
	Performance Metric	At least two trainings are provided.
Year 2	**Activity**	Present at least two trainings to increase provider competency to provide affirming, sex-positive medical care to LGBTQ+ people.
	Lead Entity	Connecticut Department of Health
	Performance Metric	At least two trainings are provided.

GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES

Objectives

- Reduce HIV-related stigma and discrimination
- Reduce disparities in new HIV infections, in knowledge of status, and along the HIV care continuum
- Address social determinants of health and co-occurring conditions that exacerbate HIV-related disparities

Strategies for Implementation by the New Haven/Fairfield Ryan White Program

Strategy 3.1	**Develop a system-wide approach for HIV service delivery using the "designing for the margins" model to reach marginalized populations that have experienced forms of systemic exclusion such as structural racism, poverty, gender and sexuality-based discrimination, incarceration, trauma, mental illness, and substance use disorder.**	
Year 1	**Activity**	Recruit community stakeholders to take part in evaluation and planning efforts.
	Lead Entities	New Haven/Fairfield Ryan White Part A Program, Greater Hartford Ryan White Part A Program
	Performance Metric	Participation by a diverse coalition of community stakeholders.
Year 1	**Activity**	Evaluate the current delivery of HIV prevention care services and identify structural vulnerabilities for populations experiencing health disparities (people of color, unstably housed individuals, youth and young adults, transgender individuals, and people living in rural areas).
	Lead Entities	New Haven/Fairfield Ryan White Part A Program, Greater Hartford Ryan White Part A Program
	Performance Metric	Evaluation completed by February 28, 2023.
Year 2	**Activity**	Create the framework for a revised systems-wide approach to HIV service delivery that focuses on reaching the most marginalized populations to address disparities in health outcomes.
	Lead Entities	New Haven/Fairfield Ryan White Part A Program, Greater Hartford Ryan White Part A Program
	Performance Metric	Framework completed by February 29, 2024.

Strategy 3.2	Engage Black faith leaders to educate their congregations and communities on HIV to increase awareness and reduce stigma and discrimination toward people living with HIV. Incorporate faith-based initiatives into NHFFRWP quality improvement activities.	
Planning & Preparation	**Activity**	Host a presentation series focused on how Black faith communities can address HIV in their communities.
	Lead Entities	New Haven/Fairfield Ryan White Part A Program, Greater Hartford Ryan White Part A Program
	Performance Metric	The presentation series is completed.
Planning & Preparation	**Activity**	Facilitate Black faith leaders to complete a planning initiative to create a one-year plan to address HIV awareness, stigma, and discrimination.
	Lead Entities	New Haven/Fairfield Ryan White Part A Program, Greater Hartford Ryan White Part A Program
	Performance Metric	The one-year plan is completed by February 28, 2022.
Year 1	**Activity**	Implement the one-year plan for Black faith leaders to address HIV awareness, stigma, and discrimination. Incorporate faith-based initiatives into NHFFRWP quality management activities.
	Lead Entities	Black faith leaders, New Haven/Fairfield Ryan White Part A Program, Greater Hartford Ryan White Part A Program
	Performance Metric	All strategies and activities identified in the one-year plan are completed by February 28, 2023. Faith-based initiatives are included in RW quality management performance metrics.
Year 2	**Activity**	Evaluate Year 1 activities. Facilitate Black faith leaders to develop and implement a Year 2 plan to address HIV awareness, stigma, and discrimination.
	Lead Entities	Black faith leaders, New Haven/Fairfield Ryan White Part A Program, Greater Hartford Ryan White Part A Program
	Performance Metric	All strategies and activities identified in the Year 2 plan are completed by February 29, 2024.

Strategy 3.3	Complete an assessment of HIV-related stigma and discrimination experienced by PWH.	
Year 1	**Activity**	Collaborate with the New Haven/Fairfield Counties HIV Services Planning Council and the Greater Hartford Ryan White Planning Council to develop a survey tool and strategy to assess local HIV-related stigma and discrimination.
	Lead Entities	New Haven/Fairfield Ryan White Part A Program, Greater Hartford Ryan White Part A Program
	Performance Metric	Development of a survey tool and assessment strategy
Year 1	**Activity**	Implement the assessment strategy.
	Lead Entities	New Haven/Fairfield Ryan White Part A Program, Greater Hartford Ryan White Part A Program
	Performance Metric	Stigma and Discrimination assessment completed by February 28, 2023.
Year 2	**Activity**	Evaluate the assessment findings and develop an action plan for reducing HIV-related stigma and discrimination.
	Lead Entities	New Haven/Fairfield Ryan White Part A Program, Greater Hartford Ryan White Part A Program
	Performance Metric	Action plan completed by February 29, 2024.

Recommended Strategies for Community Implementation

Strategy 3.4	Advocate for the passage of legislation to establish routine HIV screening in emergency rooms, hospitals, urgent care centers, and other clinical settings, and as a part of prenatal care for pregnant women.	
Planning & Preparation	**Activity**	Recruit community stakeholders to lead advocacy efforts.
	Recommended Lead Entities	HIV Stakeholders, Connecticut State Department of Health
	Performance Metric	Participation by a diverse coalition of community stakeholders.

Year 1	**Activity**	Facilitate community stakeholders to complete a planning initiative to create a one-year plan for engaging legislators, school board leadership, and community members to support the revisioning of sex education in middle and high schools.
	Recommended Lead Entities	HIV Stakeholders, Connecticut State Department of Health
	Performance Metric	The one-year plan is completed by August 2022.
Year 1	**Activity**	Implement the one-year plan.
	Recommended Lead Entities	HIV Stakeholders, Connecticut State Department of Health
	Performance Metric	The one-year plan is completed by August 2023. Legislation is successfully passed by February 29, 2024.
Year 2	**Activity**	Training is provided to clinical sites to prepare them to implement routine HIV screening.
	Recommended Lead Entity	Connecticut State Department of Health
	Performance Metric	Trainings are presented.
Year 2	**Activity**	Implementation of routine HIV screening statewide.
	Recommended Lead Entity	Connecticut State Department of Health
	Performance Metric	Routine HIV screening in all clinical settings is implemented.

Strategy 3.5	Advocate for the passage of legislation or changes to school board policies that support comprehensive, age-appropriate, LGBTQ+ inclusive, sex-positive sex education curricula in Connecticut middle and high schools.	
Year 2	**Activity**	Recruit community stakeholders to lead advocacy efforts.
	Recommended Lead Entities	HIV Stakeholders, Connecticut State Department of Health
	Performance Metric	Participation by a diverse coalition of community stakeholders.
Year 2	**Activity**	Facilitate community stakeholders to complete a planning initiative to create a comprehensive plan for engaging legislators, school board leadership, and community members to support the revisioning of sex education in middle and high schools.
	Recommended Lead Entities	HIV Stakeholders, Connecticut State Department of Health
	Performance Metric	The plan is completed by February 29, 2024.

Strategy 3.6	Develop and implement community-informed media initiatives to increase general knowledge of HIV and modern methods of HIV prevention and treatment.	
Year 1	**Activity**	Collaborate with community stakeholders to inform the development and implementation of an HIV knowledge/awareness media campaign.
	Recommended Lead Entity	Connecticut State Department of Health
	Performance Metric	At least two community listening sessions are presented.
Year 1	**Activity**	Develop an HIV knowledge/awareness media campaign using traditional and digital formats. Establish relationships with local influencers, community leaders, and other partners to support messaging on digital platforms. Create and distribute a social media tool kit to community organizations. Establish a performance monitoring and evaluation plan.
	Recommended Lead Entity	Connecticut State Department of Health

	Performance Metric	Complete all pre-launch activities related to the media campaign by February 28, 2023.
Year 2	**Activity**	Implement the HIV knowledge/awareness media campaign.
	Recommended Lead Entity	Connecticut State Department of Health
	Performance Metric	Presentation of the media campaign. Campaign performance assessed using the performance and monitoring plan.

GOAL 4: ACHIEVE INTEGRATED, COORDINATED EFFORTS THAT ADDRESS THE HIV EPIDEMIC AMONG ALL PARTNERS AND STAKEHOLDERS

Objectives

- Increase coordination of HIV programs across all levels of state/county/city governments and with faith-based and community-based organizations, the private sector, academic partners, and the community
- Enhance the quality, accessibility, sharing, and use of data, including HIV prevention and care continuum and social determinants of health data
- Improve mechanisms to measure, monitor, evaluate, report, and disseminate progress toward achieving organizational, local, and national goals

Strategies for Implementation by the New Haven/Fairfield Ryan White Program

Strategy 4.1	**Analyze Ryan White program data and state/local epi data to evaluate viral suppression among clients based on service use, provider, geographic area, demographics, etc. Identify opportunities that support increased engagement and retention in care. Priority zip codes for reengaging out of care/lost to care clients are 06704, 06705, 06902, 06854, 06810, and 06811.**	
Year 1	**Activity**	A comprehensive analysis of viral suppression among NHFFRWP clients is completed and evaluated.
	Lead Entity	New Haven/Fairfield Ryan White Part A Program
	Performance Metric	Viral suppression analysis completed.
Year 1	**Activity**	Collaborate with the Strategic Planning & Assessment Committee of the New Haven/Fairfield Counties HIV Services Planning Council to identify priorities and develop an action plan.

	Lead Entity	New Haven/Fairfield Ryan White Part A Program
	Performance Metric	Action Plan established by February 28, 2023.
Year 2	**Activity**	Implement the action plan.
	Lead Entity	New Haven/Fairfield Ryan White Part A Program
	Performance Metric	Strategies and activities identified in the action plan are completed by February 29, 2024.

Recommended Strategies for Community Implementation

Strategy 4.2	**Reestablish the Connecticut State Department of Health's common data collection and reporting system. This will support local health departments and community-based organizations to complete data-driven HIV, hepatitis, and STI disease investigation activities, engage out-of-care PWH into care, and address geographic disparities in real time.**	
Year 1	**Activity**	Address provider concerns about using multiple systems to collect HIV, hepatitis, and STI programmatic data. Develop an action plan to reinstate the previously used data collection and reporting system.
	Recommended Lead Entity	Connecticut State Department of Health
	Performance Metric	Uniform data collection is reestablished by February 28, 2023.

Strategy 4.3	**Engage PWH, Ryan White Programs, planning bodies, and community stakeholders to evaluate the status of current relationships and establish a shared vision and structure for future collaboration.**	
Year 1	**Activity**	Facilitate HIV programs, planning bodies, and community stakeholders to develop guiding principles for maintaining collaboration, trust, and transparency.
	Recommended Lead Entity	Connecticut State Department of Health
	Performance Metric	Guiding principles for community collaboration are established by February 28, 2023.

APPENDIX 1: STRATEGIES IDENTIFIED DURING ENGAGEMENT SESSIONS WITH PLANNING BODIES, TASK FORCES, AND PROVIDERS

HIV TESTING (53 ideas)

Diversify and expand HIV testing sites	9 mentions
Opt-out HIV testing	7 mentions
Increase testing (general)	6 mentions
Make routine HIV testing a standard of care	6 mentions
Mandatory HIV testing	4 mentions
Expand self-test options	4 mentions
Incentives for HIV testing	3 mentions
Minimize testing barriers	3 mentions
Promote HIV testing	2 mentions
Easier access to HIV testing	2 mentions
Rapid linkage to care	2 mentions
Allow new HIV tests to be used	2 mentions
Streamline HIV testing	1 mention
HIV testing card as proof of status	1 mention
Use mother to child prevention/care model	1 mention

EDUCATION (52 ideas)

Age-appropriate HIV/STD/Sex positivity education for youth	12 mentions
Comprehensive sex education in schools	12 mentions
HIV education for the community	11 mentions
Stigma reduction	7 mentions
Peer education	4 mentions
Access to HIV information	3 mentions
Educate parents and families on HIV/STDs/sex	3 mentions

POLICY REVISIONS

(40 ideas, includes policy-related mentions from other strategies)

Age-appropriate HIV/STD/sex positivity education for youth	12 mentions
Opt-out HIV testing	7 mentions
Free, accessible, diverse PrEP services	7 mentions
Make routine HIV testing a standard of care	6 mentions
Mandatory HIV testing	4 mentions
General policy issues	3 mentions
Syringe programs (general)	1 mention

ACCESS TO CARE (35 ideas)

General "Easy Access" statements	9 mentions
Free, accessible, diverse PrEP services	7 mentions
Universal HIV testing	2 mentions
Equitable Care	2 mentions
Rapid Start linkage-to-care	2 mentions

INNOVATION (32 ideas)

Ideas for innovation	14 mentions
Incentivize testing and care	3 mentions
Providers offer comprehensive services	3 mentions
Administration is open, honest, transparent	3 mentions
Peer-to-peer connections	3 mentions
HIV jobs and leadership opportunities for PWH	2 mentions
Foster dignity for all	2 mentions
Innovative stigma reduction campaigns	2 mentions

SYSTEMS IMPROVEMENTS (27 ideas)

Specific systems improvements	7 mentions
Eliminate institutional racism/stigma/inequities	6 mentions
Address administrative burden	5 mentions
One-stop access to services	5 mentions
Data-informed care	2 mentions
Healthcare access (general)	2 mentions

PRE-EXPOSURE PROPHYLAXIS (PrEP) (26 ideas)

More PrEP education	8 mentions
Free universal PrEP	5 mentions
Media campaigns	4 mentions
Increase use of PrEP (general comments)	3 mentions
Innovative PrEP services	3 mentions
Educate providers and consumers	2 mentions
Less PrEP messaging - more HIV messaging	1 mention

STIGMA REDUCTION (26 ideas)

Eliminate stigma (general)	7 mentions
Address stigma tailored to priority populations and providers	6 mentions
Educate the community to reduce stigma	4 mentions
Anti-stigma campaign	4 mentions
Innovative stigma reduction initiatives	2 mentions
Provider stigma reduction initiatives	2 mentions
Client disclosure to reduce stigma	1 mention

CLIENT-CENTERED ACTIVITIES (25 ideas)

Personal development opportunities	6 mentions
Peer-to-peer connection	6 mentions
Address barriers to care	4 mentions
Medication compliance	3 mentions
Incentivized testing and care	3 mentions
Improve health literacy	2 mentions
Community events for PWH	1 mention

COMMUNITY CONNECTION (23 ideas)

Greater connection to diverse communities	9 mentions
General community engagement statements	4 mentions
Educate communities	3 mentions

Methods to get community input	3 mentions
Expand community HIV leadership	2 mentions
Political support	2 mentions

MEDIA INITIATIVES (23 ideas)

More media (general)	6 mentions
Specific media campaigns	5 mentions
Social media engagement	4 mentions
TV/high-profile media	3 mentions
Campaigns to reduce stigma	3 mentions
Home test kit promotion	1 mention
Use of innovative campaigns	1 mention

COLLABORATION (20 ideas)

Enhance connections with partners	6 mentions
Health department/provider collaboration and transparency	5 mentions
Coordinated provider efforts to keep PWH in care	5 mentions
Engage community in prevention and care efforts	4 mentions

PEER MENTORING (17 ideas)

Increase peer-led initiatives	5 mentions
More peer support groups	5 mentions
Peer sharing	4 mentions
Job and leadership opportunities for PWH	2 mentions
Innovative peer media campaign	1 mention

FUNDING (13 ideas)

More funding in general	5 mentions
More funding for specific initiatives	5 mentions
Eliminate funding silos	3 mentions

UNDETECTABLE=UNTRANSMITTABLE (13 ideas)

Promote U=U science	4 mentions
U=U media campaign	3 mentions
U=U (general)	3 mentions
U=U to reduce stigma, condom fatigue	2 mentions
Providers educate clients on U=U via technology	1 mention

OUTREACH (11 ideas)

Increase outreach	5 mentions
Outreach to priority communities	4 mentions
Outreach to IDU	2 mentions

VACCINE/CURE (11 ideas)

Need for a vaccine	4 mentions
Desire and ability to find a cure	3 mentions
Funding for research and vaccine distribution	3 mentions
Promote vaccine as a cure, not a treatment	1 mention

CONDOMS (10 ideas)

Access to condoms	5 mentions
Safer sex education	2 mentions
Address condom fatigue	2 mentions
Condom outreach	1 mention

HEALTH LITERACY (9 ideas)

Eliminate the digital divide	4 mentions
Make sexual health information easy to access	3 mentions
Direct connections with PWH	2 mentions

HOUSING (8 ideas)

Increase housing availability for priority populations	7 mentions
Housing as a gateway to health	1 mention

PROVIDER EDUCATION (8 ideas)

Competency/humility training for providers	3 mentions
PrEP education for providers	3 mentions
General HIV training for providers	2 mentions

SSPs & HARM REDUCTION (8 ideas)

Harm reduction education and services	5 mentions
Comprehensive services at agencies	2 mentions
Syringe programs (general)	1 mention

COLLABORATION WITH THE FAITH COMMUNITY (7 ideas)

Connect LGBTQ and Faith communities	3 mentions
Faith leaders in harm and stigma reduction	2 mentions
Educating our churches	1 mention
Grants to churches to provide HIV education	1 mention

ADDRESS HIV LIKE COVID (5 ideas)

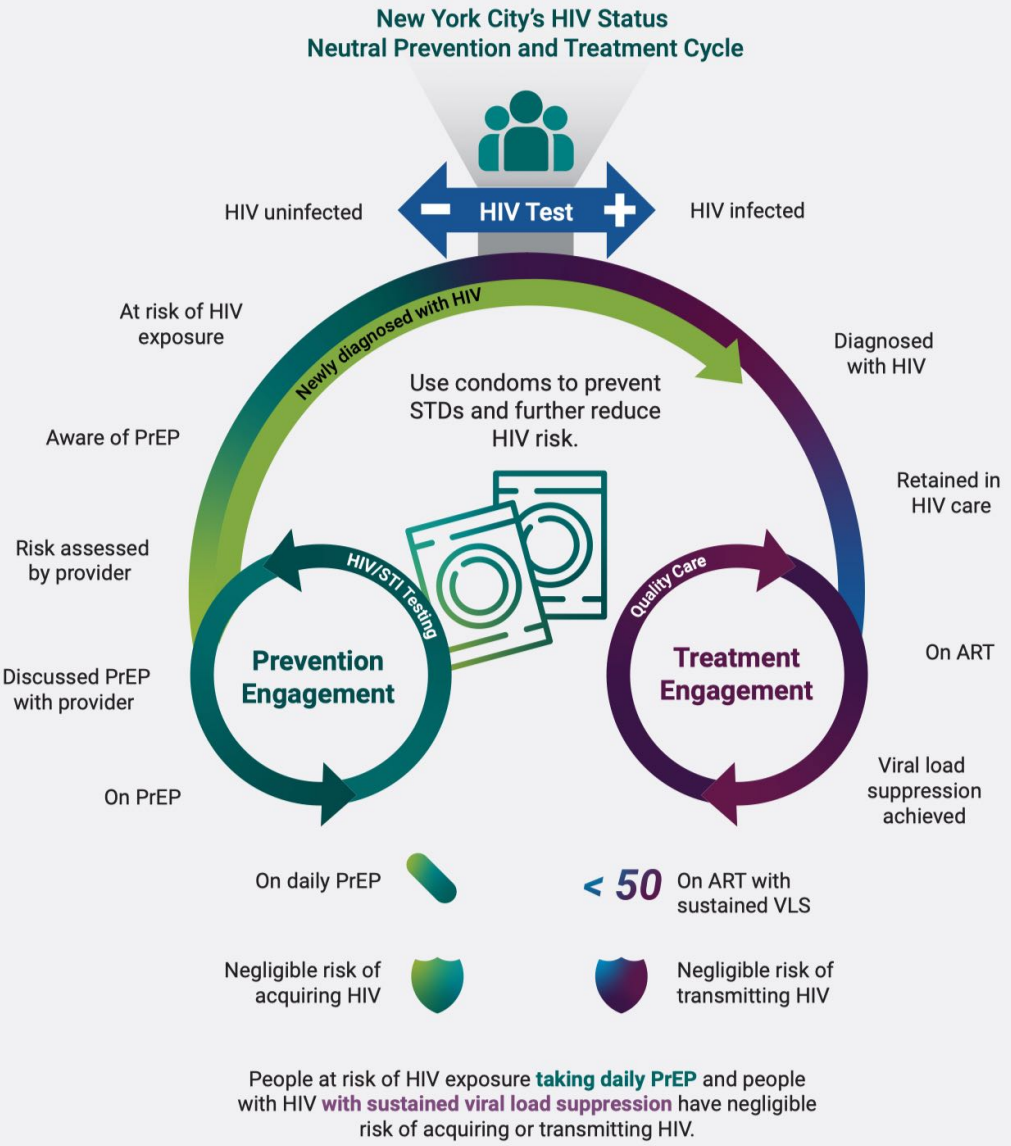
Adapt Covid-19 response methods to HIV	4 mentions
HIV testing card as proof of status	1 mention

RESEARCH (2 ideas)

More research—education, meds, treatment	2 mentions

APPENDIX 2: STATUS NEUTRAL APPROACH TO HIV PREVENTION AND CARE

Adoption of a status neutral approach to HIV services—in which HIV testing serves as an entry point to services regardless of positive or negative result—can improve testing as well as prevention and care outcomes. In this approach, people diagnosed with HIV are linked to care and treatment services as quickly as possible to achieve and maintain viral suppression, which both protects their own health and prevents transmission.



New York City's HIV status neutral prevention and treatment cycle.

Source: HIV National Strategic Plan, page 28

APPENDIX 3: HIV INCIDENCE, NEW HAVEN TGA, 2010 to 2019

HIV Infection Cases by Year of Diagnosis, Sex, Race, Risk, and Age Group, New Haven EMA, 2010 to 2019

		Sex		Race/ethnicity				Transmission Category							Age at diagnosis			
	Total	Female	Male	Black/African American	Hispanic/Latino	Other races	White	Heterosexual contact	MSM	MSM and IDU	PWID	Perinatal	Presumed Heterosexual contact	Unknown	<13	13-19	20-44	45+
	Number	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
Diagnosis Year																		
2010	202	31.7	68.3	49.0	26.2	1.0	23.8	35.1	36.1	1.5	11.9	0	6.4	8.9	0	5.9	60.4	33.7
2011	186	26.3	73.7	44.6	25.8	2.2	27.4	30.6	41.4	2.2	7.0	0.5	4.8	13.4	0	3.2	62.9	33.9
2012	173	27.2	72.8	49.1	25.4	2.3	23.1	31.8	45.7	1.2	8.1	0	3.5	9.8	0	5.2	65.9	28.9
2013	178	19.1	80.9	39.3	32.0	2.2	26.4	29.8	50.0	0.6	9.6	1.1	0.6	8.4	0.6	5.6	57.9	36.0
2014	186	28.0	72.0	49.5	25.3	2.7	22.6	30.6	48.9	1.1	5.9	0	5.4	8.1	0	4.3	60.8	34.9
2015	147	23.8	76.2	43.5	29.3	2.7	24.5	27.2	55.1	2.7	4.1	0	4.1	6.8	0	3.4	63.9	32.7
2016	169	20.1	79.9	44.4	29.0	3.6	23.1	23.7	58.0	2.4	3.6	0	2.4	10.1	0.6	2.4	66.9	30.2
2017	151	27.8	72.2	47.7	28.5	3.3	20.5	33.1	47.7	2.6	6.0	0	1.3	9.3	0	5.3	62.9	31.8
2018	136	26.5	73.5	48.5	25.7	3.7	22.1	29.4	51.5	2.2	2.2	0	6.6	8.1	0	3.7	59.6	36.8
2019	112	26.8	73.2	46.4	24.1	5.4	24.1	23.2	53.6	0	5.4	1.8	3.6	12.5	0.9	6.3	61.6	31.3
Total	1,640	25.8	74.2	46.2	27.2	2.7	23.8	29.8	48.2	1.6	6.6	0.3	3.9	9.5	0.2	4.5	62.3	33.0

This table presents HIV Infection cases using the year the person was first diagnosed. The term HIV Infection is used to refer to three categories of diagnoses collectively:
1 - persons with a diagnosis of HIV infection (not AIDS)
2 - a diagnosis of HIV infection and a later diagnosis of AIDS
3 - concurrent diagnoses of HIV and AIDS.

Source: HIV Surveillance Registry for cases reported through December 23, 2020
Data provided by the Connecticut State Department of Public Health

APPENDIX 4: HIV PREVALENCE, NEW HAVEN EMA, 2019

People Living with HIV Infection by Sex, Race, Age and Risk, New Haven EMA, 2019

	Total		Mode of Transmission															
			MSM		PWID		MSM and IDU		Heterosexual contact		Perinatal		Presumed Heterosexual contact		Other		Unknown	
	N	% of total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total
Total	6,082	100.0	1,910	31.4	1,505	24.7	119	2.0	1,755	28.9	97	1.6	180	3.0	9	0.1	507	8.3
Sex																		
Male	4,004	65.8	1,910	47.7	941	23.5	119	3.0	599	15.0	57	1.4	0	0	6	0.1	372	9.3
Female	2,078	34.2	0	0	564	27.1	0	0	1,156	55.6	40	1.9	180	8.7	3	0.1	135	6.5
Race/ethnicity																		
Black/African American	2,323	38.2	462	19.9	586	25.2	32	1.4	888	38.2	47	2.0	108	4.6	2	0.1	198	8.5
Hispanic/Latino	1,968	32.4	564	28.7	559	28.4	36	1.8	570	29.0	38	1.9	48	2.4	1	0.1	152	7.7
White	1,625	26.7	819	50.4	327	20.1	44	2.7	257	15.8	11	0.7	21	1.3	6	0.4	140	8.6
Other races	166	2.7	65	39.2	33	19.9	7	4.2	40	24.1	1	0.6	3	1.8	0	0	17	10.2
Current Age																		
<13	3	0.0	0	0	0	0	0	0	0	0	2	66.7	0	0	0	0	1	33.3
13-19	18	0.3	9	50.0	0	0	0	0	0	0	6	33.3	0	0	0	0	3	16.7
20-44	1,555	25.6	776	49.9	104	6.7	28	1.8	386	24.8	89	5.7	56	3.6	1	0.1	115	7.4
45+	4,506	74.1	1,125	25.0	1,401	31.1	91	2.0	1,369	30.4	0	0	124	2.8	8	0.2	388	8.6

Data based on last known residence address as of 2019. Includes persons known to be incarcerated. The term HIV Infection is used to refer to three categories of diagnoses collectively:
1 - persons with a diagnosis of HIV infection (not AIDS)
2 - a diagnosis of HIV infection and a later diagnosis of AIDS
3 - concurrent diagnoses of HIV and AIDS

Source: HIV Surveillance Registry for cases reported through December 23, 2020
Data provided by the Connecticut State Department of Public Health

APPENDIX 5: HIV INCIDENCE AND PREVALENCE BY REGION

NEW HAVEN

Recently Diagnosed HIV cases by Risk, Sex, Race, and Age Group, New Haven, 2015 to 2019

	Total		Mode of Transmission											
			MSM		PWID		Heterosexual contact		Perinatal		Presumed Heterosexual contact		Unknown	
	N	% of total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total
Total	147	100.0	93	63.3	4	2.7	35	23.8	1	0.7	4	2.7	10	6.8
Sex														
Male	121	82.3	93	76.9	4	3.3	15	12.4	0	0	0	0	9	7.4
Female	26	17.7	0	0	0	0	20	76.9	1	3.8	4	15.4	1	3.8
Race/ethncity														
Black/African American	88	59.9	44	50.0	2	2.3	29	33.0	1	1.1	4	4.5	8	9.1
Hispanic/Latino	40	27.2	33	82.5	0	0	5	12.5	0	0	0	0	2	5.0
White	16	10.9	14	87.5	1	6.3	1	6.3	0	0	0	0	0	0
Other races	3	2.0	2	66.7	1	33.3	0	0	0	0	0	0	0	0
Age at diagnosis														
<20	13	8.8	12	92.3	0	0	0	0	1	7.7	0	0	0	0
20-29	59	40.1	46	78.0	1	1.7	10	16.9	0	0	1	1.7	1	1.7
30-39	31	21.1	19	61.3	0	0	9	29.0	0	0	1	3.2	2	6.5
40-49	20	13.6	7	35.0	1	5.0	6	30.0	0	0	1	5.0	5	25.0
50+	24	16.3	9	37.5	2	8.3	10	41.7	0	0	1	4.2	2	8.3

This table presents HIV Infection cases using the year the person was first diagnosed. The term HIV Infection is used to refer to three categories of diagnoses collectively:
1 - persons with a diagnosis of HIV infection (not AIDS)
2 - a diagnosis of HIV infection and a later diagnosis of AIDS
3 - concurrent diagnoses of HIV and AIDS.

Source: HIV Surveillance Registry for cases reported through December 23, 2020
Data provided by the Connecticut State Department of Public Health

People Living with HIV Infection by Sex, Race, Age Group and Risk, New Haven, 2019

	Total		Transmission Category															
			MSM		PWID		MSM and IDU		Heterosexual contact		Perinatal		Presumed Heterosexual contact		Other		Unknown	
	N	% of total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total
Total	1,326	100	343	26	431	33	39	3	388	29	22	2	27	2	2	0	74	6
Sex																		
Male	855	64	343	40	282	33	39	5	120	14	12	1	0	0	1	0	58	7
Female	471	36	0	0	149	32	0	0	268	57	10	2	27	6	1	0	16	3
Race/ethnicity																		
Black/African American	679	51	143	21	208	31	14	2	235	35	15	2	20	3	1	0	43	6
Hispanic/Latino	391	29	85	22	147	38	14	4	113	29	6	2	4	1	0	0	22	6
White	216	16	100	46	66	31	9	4	30	14	1	0	3	1	1	0	6	3
Other races	40	3	15	38	10	25	2	5	10	25	0	0	0	0	0	0	3	8
Current Age																		
<20	7	1	3	43	0	0	0	0	0	0	2	29	0	0	0	0	2	29
20-29	101	8	74	73	2	2	0	0	11	11	9	9	3	3	0	0	2	2
30-39	133	10	66	50	9	7	3	2	37	28	11	8	2	2	0	0	5	4
40-49	233	18	61	26	51	22	7	3	89	38	0	0	7	3	1	0	17	7
50-59	441	33	86	20	156	35	18	4	147	33	0	0	11	2	0	0	23	5
60+	411	31	53	13	213	52	11	3	104	25	0	0	4	1	1	0	25	6

Data based on last known residence address as of 2019. Includes person known to be incarcerated. The term HIV Infection is used to refer to three categories of diagnoses collectively:
1 - persons with a diagnosis of HIV infection (not AIDS)
2 - a diagnosis of HIV infection and a later diagnosis of AIDS
3 - concurrent diagnoses of HIV and AIDS

Source: HIV Surveillance Registry for cases reported through December 23, 2020
Data provided by the Connecticut State Department of Public Health

WATERBURY

Recently Diagnosed HIV cases by Risk, Sex, Race, and Age Group, Waterbury, 2015 to 2019

	Total		Mode of Transmission											
			MSM		PWID		MSM and IDU		Heterosexual contact		Presumed Heterosexual contact		Unknown	
	N	% of total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total
Total	100	100.0	40	40.0	7	7.0	5	5.0	33	33.0	6	6.0	9	9.0
Sex														
Male	62	62.0	40	64.5	3	4.8	5	8.1	9	14.5	0	0	5	8.1
Female	38	38.0	0	0	4	10.5	0	0	24	63.2	6	15.8	4	10.5
Race/ethncity														
Black/African American	53	53.0	16	30.2	2	3.8	0	0	25	47.2	5	9.4	5	9.4
Hispanic/Latino	27	27.0	17	63.0	2	7.4	1	3.7	5	18.5	0	0	2	7.4
White	16	16.0	7	43.8	3	18.8	2	12.5	2	12.5	1	6.3	1	6.3
Other races	4	4.0	0	0	0	0	2	50.0	1	25.0	0	0	1	25.0
Age at diagnosis														
<20	5	5.0	3	60.0	0	0	0	0	1	20.0	0	0	1	20.0
20-29	31	31.0	21	67.7	2	6.5	2	6.5	5	16.1	0	0	1	3.2
30-39	21	21.0	7	33.3	0	0	0	0	10	47.6	2	9.5	2	9.5
40-49	28	28.0	7	25.0	3	10.7	3	10.7	10	35.7	2	7.1	3	10.7
50+	15	15.0	2	13.3	2	13.3	0	0	7	46.7	2	13.3	2	13.3

This table presents HIV Infection cases using the year the person was first diagnosed. The term HIV Infection is used to refer to three categories of diagnoses collectively:
1 - persons with a diagnosis of HIV infection (not AIDS)
2 - a diagnosis of HIV infection and a later diagnosis of AIDS
3 - concurrent diagnoses of HIV and AIDS.

Source: HIV Surveillance Registry for cases reported through December 23, 2020
Data provided by the Connecticut State Department of Public Health

People Living with HIV Infection by Sex, Race, Age Group and Risk, Waterbury, 2019

	Total		Transmission Category													
			MSM		PWID		MSM and IDU		Heterosexual contact		Perinatal		Presumed Heterosexual contact		Unknown	
	N	% of total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total
Total	697	100	172	25	216	31	15	2	201	29	12	2	23	3	58	8
Sex																
Male	412	59	172	42	122	30	15	4	56	14	9	2	0	0	38	9
Female	285	41	0	0	94	33	0	0	145	51	3	1	23	8	20	7
Race/ethnicity																
Black/African American	233	33	54	23	67	29	1	0	74	32	5	2	16	7	16	7
Hispanic/Latino	316	45	76	24	103	33	6	2	89	28	7	2	4	1	31	10
White	139	20	41	29	44	32	6	4	35	25	0	0	3	2	10	7
Other races	9	1	1	11	2	22	2	22	3	33	0	0	0	0	1	11
Current Age																
<20	3	0	2	67	0	0	0	0	0	0	1	33	0	0	0	0
20-29	57	8	36	63	3	5	2	4	7	12	7	12	0	0	2	4
30-39	89	13	38	43	4	4	1	1	27	30	4	4	6	7	9	10
40-49	134	19	29	22	34	25	4	3	45	34	0	0	6	4	16	12
50-59	239	34	45	19	88	37	5	2	72	30	0	0	7	3	22	9
60+	175	25	22	13	87	50	3	2	50	29	0	0	4	2	9	5

Data based on last known residence address as of 2019
The term HIV Infection is used to refer to three categories of diagnoses collectively:
1 - persons with a diagnosis of HIV infection (not AIDS)
2 - a diagnosis of HIV infection and a later diagnosis of AIDS
3 - concurrent diagnoses of HIV and AIDS

Source: HIV Surveillance Registry for cases reported through December 23, 2020
Data provided by the Connecticut State Department of Public Health

BRIDGEPORT

Recently Diagnosed HIV cases by Risk, Sex, Race, and Age Group, Bridgeport, 2015 to 2019

	Total		Mode of Transmission											
			MSM		PWID		MSM and IDU		Heterosexual contact		Presumed Heterosexual contact		Unknown	
	N	% of total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total
Total	141	100.0	63	44.7	5	3.5	1	0.7	50	35.5	5	3.5	17	12.1
Sex														
Male	95	67.4	63	66.3	2	2.1	1	1.1	16	16.8	0	0	13	13.7
Female	46	32.6	0	0	3	6.5	0	0	34	73.9	5	10.9	4	8.7
Race/ethncity														
Black/African American	77	54.6	34	44.2	2	2.6	1	1.3	30	39.0	4	5.2	6	7.8
Hispanic/Latino	42	29.8	19	45.2	2	4.8	0	0	15	35.7	0	0	6	14.3
White	18	12.8	9	50.0	1	5.6	0	0	3	16.7	1	5.6	4	22.2
Other races	4	2.8	1	25.0	0	0	0	0	2	50.0	0	0	1	25.0
Age at diagnosis														
<20	4	2.8	3	75.0	0	0	0	0	0	0	0	0	1	25.0
20-29	51	36.2	35	68.6	0	0	1	2.0	11	21.6	1	2.0	3	5.9
30-39	27	19.1	12	44.4	2	7.4	0	0	10	37.0	0	0	3	11.1
40-49	27	19.1	5	18.5	1	3.7	0	0	17	63.0	2	7.4	2	7.4
50+	32	22.7	8	25.0	2	6.3	0	0	12	37.5	2	6.3	8	25.0

This table presents HIV Infection cases using the year the person was first diagnosed. The term HIV Infection is used to refer to three categories of diagnoses collectively:
1 - persons with a diagnosis of HIV infection (not AIDS)
2 - a diagnosis of HIV infection and a later diagnosis of AIDS
3 - concurrent diagnoses of HIV and AIDS.

Source: HIV Surveillance Registry for cases reported through December 23, 2020
Data provided by the Connecticut State Department of Public Health

People Living with HIV Infection by Sex, Race, Age Group and Risk, Bridgeport, 2019

	Total		Transmission Category													
			MSM		PWID		MSM and IDU		Heterosexual contact		Perinatal		Presumed Heterosexual contact		Unknown	
	N	% of total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total
Total	1,225	100	275	22	327	27	19	2	434	35	18	1	44	4	108	9
Sex																
Male	725	59	275	38	210	29	19	3	137	19	9	1	0	0	75	10
Female	500	41	0	0	117	23	0	0	297	59	9	2	44	9	33	7
Race/ethnicity																
Black/African American	580	47	99	17	135	23	9	2	240	41	8	1	28	5	61	11
Hispanic/Latino	481	39	118	25	150	31	7	1	155	32	10	2	14	3	27	6
White	150	12	55	37	39	26	3	2	35	23	0	0	2	1	16	11
Other races	14	1	3	21	3	21	0	0	4	29	0	0	0	0	4	29
Current Age																
<20	2	0	0	0	0	0	0	0	0	0	1	50	0	0	1	50
20-29	73	6	37	51	1	1	2	3	18	25	10	14	1	1	4	5
30-39	142	12	63	44	9	6	1	1	45	32	7	5	8	6	9	6
40-49	237	19	58	24	45	19	2	1	96	41	0	0	13	5	23	10
50-59	408	33	83	20	119	29	10	2	151	37	0	0	11	3	34	8
60+	363	30	34	9	153	42	4	1	124	34	0	0	11	3	37	10

Data based on last known residence address as of 2019. Includes person known to be incarcerated. The term HIV Infection is used to refer to three categories of diagnoses collectively:
1 - persons with a diagnosis of HIV infection (not AIDS)
2 - a diagnosis of HIV infection and a later diagnosis of AIDS
3 - concurrent diagnoses of HIV and AIDS

Source: HIV Surveillance Registry for cases reported through December 23, 2020
Data provided by the Connecticut State Department of Public Health

STAMFORD

Recently Diagnosed HIV Cases by Sex, Race, Age and Risk, Stamford, 2015 to 2019

	N	% of total
Total	59	100.0
Sex		
Male	51	86.4
Female	8	13.6
Race/ethncity		
Black/African American	25	42.4
Hispanic/Latino	14	23.7
White	12	20.3
Other races	8	13.6
Age at diagnosis		
<20	2	3.4
20-29	15	25.4
30-39	14	23.7
40-49	14	23.7
50+	14	23.7
Mode of Transmission		
MSM	30	50.8
PWID	2	3.4
MSM and IDU	2	3.4
Heterosexual contact	15	25.4
Presumed Heterosexual contact	1	1.7
Unknown	9	15.3

This table presents HIV Infection cases using the year the person was first diagnosed. The term HIV Infection is used to refer to three categories of diagnoses collectively:
1 - persons with a diagnosis of HIV infection (not AIDS)
2 - a diagnosis of HIV infection and a later diagnosis of AIDS
3 - concurrent diagnoses of HIV and AIDS.

Source: HIV Surveillance Registry for cases reported through December 23, 2020
Data provided by the Connecticut State Department of Public Health

People Living with HIV Infection by Sex, Race, Risk and Age, Stamford, 2019

	Total	
	N	% of total
Total	467	100.0
Sex		
Male	340	72.8
Female	127	27.2
Race/ethnicity		
Black/African American	187	40.0
Hispanic/Latino	153	32.8
White	106	22.7
Other races	21	4.5
Transmission Category		
MSM	173	37.0
PWID	91	19.5
MSM and IDU	7	1.5
Heterosexual contact	124	26.6
Perinatal	6	1.3
Presumed Heterosexual contact	21	4.5
Other	1	0.2
Unknown	44	9.4
Current Age		
20-29	27	5.8
30-39	53	11.3
40-49	78	16.7
50-59	148	31.7
60+	161	34.5

Data based on last known residence address as of 2019
The term HIV Infection is used to refer to three categories of diagnoses collectively:
1 - persons with a diagnosis of HIV infection (not AIDS)
2 - a diagnosis of HIV infection and a later diagnosis of AIDS
3 - concurrent diagnoses of HIV and AIDS

Source: HIV Surveillance Registry for cases reported through December 23, 2020
Data provided by the Connecticut State Department of Public Health

NORWALK

Recently Diagnosed HIV Cases by Sex, Race, Age and Risk, Norwalk, 2015 to 2019

	N	% of total
Total	27	100.0
Sex		
Male	17	63.0
Female	10	37.0
Race/ethncity		
Black/African American	11	40.7
Hispanic/Latino	11	40.7
White	4	14.8
Other races	1	3.7
Age at diagnosis		
20-29	6	22.2
30-39	5	18.5
40-49	5	18.5
50+	11	40.7
Mode of Transmission		
MSM	13	48.1
Heterosexual contact	12	44.4
Presumed Heterosexual contact	2	7.4

This table presents HIV Infection cases using the year the person was first diagnosed. The term HIV Infection is used to refer to three categories of diagnoses collectively:
1 - persons with a diagnosis of HIV infection (not AIDS)
2 - a diagnosis of HIV infection and a later diagnosis of AIDS
3 - concurrent diagnoses of HIV and AIDS.

Source: HIV Surveillance Registry for cases reported through December 23, 2020
Data provided by the Connecticut State Department of Public Health

People Living with HIV Infection by Sex, Race, Risk, and Age, Norwalk, 2019

	Total	
	N	% of total
Total	296	100.0
Sex		
Male	191	64.5
Female	105	35.5
Race/ethnicity		
Black/African American	97	32.8
Hispanic/Latino	91	30.7
White	95	32.1
Other races	13	4.4
Transmission Category		
MSM	103	34.8
PWID	56	18.9
MSM and IDU	6	2.0
Heterosexual contact	84	28.4
Perinatal	7	2.4
Presumed Heterosexual contact	16	5.4
Other	1	0.3
Unknown	23	7.8
Current Age		
20-29	17	5.7
30-39	32	10.8
40-49	65	22.0
50-59	94	31.8
60+	88	29.7

Data based on last known residence address as of 2019
The term HIV Infection is used to refer to three categories of diagnoses collectively:
1 - persons with a diagnosis of HIV infection (not AIDS)
2 - a diagnosis of HIV infection and a later diagnosis of AIDS
3 - concurrent diagnoses of HIV and AIDS

Source: HIV Surveillance Registry for cases reported through December 23, 2020
Data provided by the Connecticut State Department of Public Health

DANBURY

Recently Diagnosed HIV Cases by Sex, Race, Age and Risk, Danbury, 2015 to 2019

	N	% of total
Total	23	100.0
Sex		
Male	15	65.2
Female	8	34.8
Race/ethncity		
Black/African American	6	26.1
Hispanic/Latino	13	56.5
White	4	17.4
Age at diagnosis		
20-29	4	17.4
30-39	7	30.4
40-49	10	43.5
50+	2	8.7
Mode of Transmission		
MSM	12	52.2
PWID	1	4.3
MSM and IDU	1	4.3
Heterosexual contact	6	26.1
Presumed Heterosexual contact	1	4.3
Unknown	2	8.7

This table presents HIV Infection cases using the year the person was first diagnosed. The term HIV Infection is used to refer to three categories of diagnoses collectively:
1 - persons with a diagnosis of HIV infection (not AIDS)
2 - a diagnosis of HIV infection and a later diagnosis of AIDS
3 - concurrent diagnoses of HIV and AIDS.

Source: HIV Surveillance Registry for cases reported through December 23, 2020
Data provided by the Connecticut State Department of Public Health

People Living with HIV Infection by Sex, Race, Risk, and Age, Danbury, 2019

	Total	
	N	% of total
Total	215	100.0
Sex		
Male	137	63.7
Female	78	36.3
Race/ethnicity		
Black/African American	50	23.3
Hispanic/Latino	96	44.7
White	57	26.5
Other races	12	5.6
Transmission Category		
MSM	69	32.1
PWID	48	22.3
Heterosexual contact	68	31.6
Perinatal	3	1.4
Presumed Heterosexual contact	7	3.3
Unknown	20	9.3
Current Age		
20-29	13	6.0
30-39	35	16.3
40-49	51	23.7
50-59	68	31.6
60+	48	22.3

Data based on last known residence address as of 2019
The term HIV Infection is used to refer to three categories of diagnoses collectively:
1 - persons with a diagnosis of HIV infection (not AIDS)
2 - a diagnosis of HIV infection and a later diagnosis of AIDS
3 - concurrent diagnoses of HIV and AIDS

Source: HIV Surveillance Registry for cases reported through December 23, 2020
Data provided by the Connecticut State Department of Public Health

HARTFORD

Recently Diagnosed HIV cases by Risk, Sex, Race, and Age Group, Hartford, 2015 to 2019

	Total		Mode of Transmission													
			MSM		PWID		MSM and IDU		Heterosexual contact		Perinatal		Presumed Heterosexual contact		Unknown	
	N	% of total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total
Total	175	100.0	69	39.4	20	11.4	2	1.1	65	37.1	1	0.6	3	1.7	15	8.6
Sex																
Male	116	66.3	69	59.5	9	7.8	2	1.7	23	19.8	0	0	0	0	13	11.2
Female	59	33.7	0	0	11	18.6	0	0	42	71.2	1	1.7	3	5.1	2	3.4
Race/ethncity																
Black/African American	79	45.1	25	31.6	3	3.8	0	0	39	49.4	0	0	2	2.5	10	12.7
Hispanic/Latino	76	43.4	35	46.1	11	14.5	1	1.3	23	30.3	1	1.3	1	1.3	4	5.3
White	18	10.3	7	38.9	6	33.3	1	5.6	3	16.7	0	0	0	0	1	5.6
Other races	2	1.1	2	100.0	0	0	0	0	0	0	0	0	0	0	0	0
Age at diagnosis																
<20	14	8.0	7	50.0	0	0	0	0	3	21.4	1	7.1	1	7.1	2	14.3
20-29	48	27.4	29	60.4	1	2.1	0	0	15	31.3	0	0	0	0	3	6.3
30-39	42	24.0	19	45.2	8	19.0	1	2.4	11	26.2	0	0	2	4.8	1	2.4
40-49	31	17.7	6	19.4	5	16.1	1	3.2	14	45.2	0	0	0	0	5	16.1
50+	40	22.9	8	20.0	6	15.0	0	0	22	55.0	0	0	0	0	4	10.0

This table presents HIV Infection cases using the year the person was first diagnosed. The term HIV Infection is used to refer to three categories of diagnoses collectively:
1 - persons with a diagnosis of HIV infection (not AIDS)
2 - a diagnosis of HIV infection and a later diagnosis of AIDS
3 - concurrent diagnoses of HIV and AIDS.

Source: HIV Surveillance Registry for cases reported through December 23, 2020
Data provided by the Connecticut State Department of Public Health

People Living with HIV Infection by Sex, Race, Age Group and Risk, Hartford, 2019

	Total		Transmission Category															
			MSM		PWID		MSM and IDU		Heterosexual contact		Perinatal		Presumed Heterosexual contact		Other		Unknown	
	N	% of total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total
Total	1,428	100	327	23	519	36	33	2	395	28	26	2	35	2	1	0	92	6
Sex																		
Male	919	64	327	36	359	39	33	4	120	13	10	1	0	0	0	0	70	8
Female	509	36	0	0	160	31	0	0	275	54	16	3	35	7	1	0	22	4
Race/ethnicity																		
Black/African American	531	37	122	23	154	29	11	2	168	32	8	2	20	4	0	0	48	9
Hispanic/Latino	731	51	133	18	320	44	20	3	197	27	13	2	13	2	1	0	34	5
White	142	10	57	40	44	31	2	1	25	18	4	3	1	1	0	0	9	6
Other races	24	2	15	63	1	4	0	0	5	21	1	4	1	4	0	0	1	4
Current Age																		
<20	8	1	3	38	0	0	0	0	2	25	1	13	1	13	0	0	1	13
20-29	82	6	36	44	0	0	0	0	17	21	21	26	2	2	0	0	6	7
30-39	163	11	83	51	18	11	8	5	39	24	4	2	4	2	0	0	7	4
40-49	270	19	75	28	66	24	3	1	93	34	0	0	11	4	0	0	22	8
50-59	467	33	72	15	216	46	13	3	124	27	0	0	8	2	0	0	34	7
60+	438	31	58	13	219	50	9	2	120	27	0	0	9	2	1	0	22	5

Data based on last known residence address as of 2019. Includes person known to be incarcerated. The term HIV Infection is used to refer to three categories of diagnoses collectively:
1 - persons with a diagnosis of HIV infection (not AIDS)
2 - a diagnosis of HIV infection and a later diagnosis of AIDS
3 - concurrent diagnoses of HIV and AIDS

Source: HIV Surveillance Registry for cases reported through December 23, 2020
Data provided by the Connecticut State Department of Public Health