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Perspectives from community-based HIV service organization leaders on priorities in serving sexual and gender minority populations

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Abstract

Sexual and gender minority (SGM) populations experience discrimination and care-related barriers when seeking appropriate sexual health services. Using rapid assessment procedures we conducted site visits with 11 community-based HIV service agencies to identify priorities, assets, and needs related to serving SGM clients and assessed the alignment of these services with the city's local Ending the HIV Epidemic plan. We identified and mapped themes across agencies into

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the Consolidated Framework for Implementation Research domains of inner and outer settings: client-facing materials; priorities in serving SGM communities; SGM policies and protocols; collecting sexual orientation and gender identity data; training and education; and funding and scope of programs. Rapid assessment procedures can accelerate the collection and interpretation of data to help public health institutions and community partners make timely adaptations when implementing comprehensive and culturally humble sexual health services for SGM communities.

Keywords

HIV prevention; cultural humility; implementation science; LGBTQ; rapid analysis; transgender

The Ending the HIV Epidemic (EHE) in the U.S. initiative, which was announced in 2019 amid stalled progress in treatment and prevention for HIV, aims to reduce HIV incidence by 90% by 2030 through coordinated public health efforts in 57 priority jurisdictions. Philadelphia County was identified as one of these priority jurisdictions with a high number of new HIV diagnoses.(Fauci et al., 2019) In 2020, over 50% of new HIV diagnoses in Philadelphia were among cisgender men who have sex with men.(Philadelphia Department of Public Health, 2021) While local data for transgender individuals are limited, transgender persons are disproportionately affected by HIV nationally.(Centers for Disease Control and Prevention, 2021)

The Philadelphia Department of Public Health (PDPH) has developed a local EHE plan to increase HIV testing, access to biomedical HIV prevention modalities (i.e., pre-exposure prophylaxis [PrEP] and post-exposure prophylaxis [PEP]), and linkage to HIV care as a strategy to curb new HIV infections. (Philadelphia Department of Public Health, 2020) This plan aims to capacitate local health and social service providers to implement strategies that address ongoing community needs and gaps in HIV prevention and treatment to reduce health disparities and improve health outcomes. With the support and guidance of local health departments, community organizations are well positioned to create, scale-up, and implement standardized, evidence-based practices. Additionally, community-based organizations are able tailor their service provision to align with the specific needs of the communities they serve.(Bauermeister et al., 2009)

Responding to the HIV infection disparities experienced by racial/ethnic and sexual and gender minority communities, the city's plan underscores the need to ensure that these HIV prevention strategies are available, accessible, and adoptable by these key populations – and acknowledges that supporting community-based organizations to provide HIV prevention services is foundational to achieving this goal. "Sexual and gender minority" is an umbrella term used to refer to both people who have been marginalized based on their sexual orientation (e.g., lesbian, gay, bisexual, queer, and other diverse sexual orientations) and to people who have been marginalized based on their gender identity (e.g., transgender, gender non-binary, gender expansive, and other diverse gender identities). Sexual and gender minority (SGM) individuals encounter barriers to accessing appropriate sexual health services,(Snyder et al., 2017) are less likely to have health insurance,(Fredriksen-Goldsen et al., 2013) and are more likely to encounter stigma and discrimination when interacting

with medical providers.(Ayhan et al., 2020) Black and Latinx individuals who are SGM are vulnerable to intersectional oppressions, ranging from racism in medical settings (Quinn et al., 2019) to structural disinvestment in racially segregated neighborhoods.(Lynch et al., 2021) Bolstering the delivery of comprehensive and culturally humble sexual health services (i.e., HIV testing, STI testing, PrEP services) will be critical for achieving health equity.

Cultural humility is an educational framework for training service providers to develop critical reflective practices that foster partnership and challenge power imbalances with clients.(Tervalon & Murray-Garcia, 1998) In contrast to the paradigm of cultural competence, which focuses on building knowledge and skills related to working with multicultural clients and can reinforce stereotypes and rigid notions about specific "cultures", cultural humility centers a recognition that self-awareness and openness to other viewpoints creates conditions for meaningful connection across cultural experiences.(Hook et al., 2013) This framework has been applied to educational interventions that aim to improve sexual health services for SGM patients.(Jadwin-Cakmak et al., 2020) Specifically, cultural humility has been identified as a key priority for creating inclusive and affirming health care environments for transgender and gender diverse individuals.(Kuzma et al., 2019; Lightfoot et al., 2021) Fostering cultural humility in the settings where sexual health services are delivered is an important element of the city's comprehensive EHE plan, and an assessment of the current integration of these principles into sexual health services in the city is needed.

To achieve the targets set out in the EHE initiative, quick and efficient responses from local health departments and their partners are needed to adapt and scale up services and programs. Rapid assessment procedures can provide timely and valuable insights into the needs and priorities of HIV service organizations charged with implementing these services. Rapid assessment procedures are a set of methods for collecting qualitative data using participant observation and non-directed interviewing to expediently evaluate a situation, environment, or event. (Beebe, 1995; Palinkas & Zatzick, 2019) Rapid assessment procedures have been used extensively in health services and implementation research to collect information to inform intervention development, implementation design, or clinical practice in a short period of time.(Ackerman et al., 2017; Vindrola-Padros & Vindrola-Padros, 2018)

In this study, we use rapid assessment procedures to identify priorities, assets, and needs related to serving SGM clients in HIV service organizations in Philadelphia and assess the alignment of these services with the city's local EHE plan. Drawing from published guidelines and methods for rapid assessment procedures,(Averill, 2002; Beebe, 1995; Hamilton & Finley, 2019) we conducted on-site, semi-structured interviews with key stakeholders in HIV service organizations and analyzed the resulting data using matrix analysis as a strategy for data reduction and synthesis.

METHODS

Sampling and Recruitment

The data for this study comes from an effectiveness-implementation hybrid parent study of a systems-level intervention aiming to improve the delivery of culturally humble HIV prevention services in partnership with the PDPH. The health department funded a total of 11 community-based HIV service organizations to implement strategies to provide accessible HIV prevention services. We recruited agency directors and other leadership personnel from all 11 of these organizations to participate in site inventories.

Study Procedures

We conducted site inventories based on the principles of rapid assessment procedures to generate timely preliminary data and evaluation products to the community and public health partners and inform ongoing implementation efforts to improve training and resources for HIV service organizations in Philadelphia.(Beebe, 1995) A site inventory guide was adapted from existing tools (Jadwin-Cakmak et al., 2020; Sirdenis et al., 2019) for evaluating policies, systems, and environment in clinical settings to collect and triangulate data regarding the resources for and needs among SGM clients for each agency (Supplemental Materials). Open-ended questions were asked of agency directors and other key stakeholders to elicit insights regarding policies and protocols specific to serving SGM clients, access to affirming and representative client-facing materials, trainings related to serving SGM populations, and resources tailored to SGM health and social needs (e.g., “What do you see as the most important things to focus on when you think of the services you provide to lesbian, gay, bisexual, queer and transgender youth?”). Close-ended questions were asked to determine specific agency and service characteristics (e.g., “Do you currently collect information on your patient’s sexual orientation?”). Additionally, directly observable characteristics of the agency related to services offered, clinical infrastructure, and accessibility were assessed as part of this visit (e.g., “Is there a sign on the street or on the exterior of the building announcing that HIV prevention services are available?”). This allowed us to triangulate participant perspectives with direct observations, increasing the rigor and depth of our rapid evaluation. (Beebe, 1995)

Gathering data through informal, on-site conversations with stakeholders is a strategy for gaining an “insider’s perspective” of a system or organization.(Beebe, 1995). The research team recorded responses to close ended questions, documented observable agency characteristics, and took detailed field notes and memos for open-ended questions and throughout the visits. These data formed the basis for the rapid qualitative analysis. To maximize the privacy and confidentiality of these conversations, we chose not to record the site visits. This helped to promote candid and honest conversations and reduced concerns about participants or agencies being identified.

Site visits took place between September and November 2021. Visits lasted between 60 and 120 minutes and were primarily conducted in-person at the agency site. Due to challenges related to the COVID-19 pandemic, two visits were conducted virtually over video conferencing software. This study was reviewed by the PDPH Institutional Review

Board. The site inventory activities were determined to be quality improvement activities and not human research and were considered exempt from further review. Informed consent was not collected from those participating in these inventories, and no incentives were provided for participation.

Analysis plan

Agency characteristics were summarized using information from the site inventories. To identify themes across agencies in key domains, we used rapid qualitative methods including matrix analysis.(Averill, 2002; Gale et al., 2019) Interview notes, responses to closed-ended questions from the interview guide, and directly observable characteristics of the agency were entered into a Qualtrics database with each open-ended interview question representing a domain for analysis. Key domains were exported into a tabular format and analyzed by two members of the research team (S.B. and A.M.) independently to identify themes emerging across agencies for each domain. These researchers met weekly to discuss additional themes and resolve discrepancies in theme definition. These themes were then mapped onto domains from the Consolidated Framework for Implementation Research (CFIR) to highlight the relevant facilitators and barriers to implementation of culturally humble HIV prevention services.(Damschroder et al., 2009) The CFIR framework provides tools for systematically assessing potential barriers and facilitators to the effective implementation of evidence-based practices in real world. This framework has been widely used in health services and implementation research to evaluate and inform systems-level HIV prevention. (Chayama et al., 2020; Harkness et al., 2021) Final discussions with the full team were held to reach consensus on theme definition and domain mapping.

RESULTS

Agency services, infrastructure, and accessibility

A summary of agency level characteristics related to service provision, infrastructure, and accessibility are shown in Table 1. Agencies fell into four categories based on their primary source of funding from the city: low-threshold sexual health services (i.e., streamlined clinical models improving access to patient-centered sexual health care; n=4; 36.4%), status-neutral testing services (i.e., community-based HIV testing that provides strong linkages to care and PrEP; n=6; 54.5%), community mobilization (i.e., community organizations focused on outreach, advocacy, and providing resources; n=2; 18.2%), and syringe service program (i.e., harm reduction services for individuals who inject drugs; n=1; 9.1%).

Of the 11 participating agencies, all offered HIV testing and condoms, ten (91%) offered HIV home testing kits, seven (64%) offered PrEP services on site, and seven (64%) provided testing for chlamydia and gonorrhea. Regarding gender affirming care for transgender clients, three agencies (27%) provided gender-affirming hormone therapy, and three (27%) additional agencies had a referral process for clients seeking hormone therapy. Six agencies (55%) provided at least one category of gender affirming clinical service for their clients (e.g., hormone therapy, binders/gaffs, navigation/advocacy services for transgender clients, name change and other legal document support, and prior authorization for medications).

Agencies varied in the degree of clinical infrastructure available. Seven (64%) agencies had on-site phlebotomy, three agencies (27%) had on-site pharmacies, and five (45%) reported having a relationship with a nearby pharmacy to which they referred clients. Regarding language-based accessibility, all but one agency (91%) reported having resources to provide services in Spanish, including at least one staff member who spoke Spanish fluently. Three agencies (27%) reported supporting at least one additional language beyond English and Spanish (Russian, American Sign Language, French, and Amharic). Seven agencies (64%) were open in the evening or on the weekend at least once per week. Eight agencies (73%) reported offering telehealth services.

CFIR Themes

Six themes arose from rapid qualitative analysis related to facilitators and barriers to providing culturally humble services for SGM clients and were mapped on the CFIR domains of Inner Setting and Outer Setting. The Inner Setting domain includes facilitators and barriers related to the specific setting of the organization, such as organizational culture, support from leadership, and available resources. The Outer Setting domain encompasses facilitators and barriers related to the context that the organization works in, such as external laws, policies, and regulations, as well as relationships with other organizations or stakeholders. Themes did not differ significantly based on the program type of the agencies (i.e., low threshold sexual health services, status neutral testing services, community mobilization, and syringe service program).

Inner Setting

Client-facing Materials that Affirm SGM and Other Diverse Identities.: Most agencies (n=9, 82%) had affirming client-facing materials tailored to SGM clients, such as brochures, handouts, or posters. SGM-affirming signage included posters related to sexual health, pride flags and stickers, and an art display featuring SGM artists. One agency obtained feedback regarding its client-facing materials from SGM youth, who recommended integrating SGM affirming signage as part of a constellation of signage featuring diverse identities and sexualities. This feedback aligned with other agencies' reported interest in expanding their SGM affirming signage to better reflect the diversity of sexual orientations, gender identities, racial backgrounds, and class backgrounds among their clients. Agencies also reported need for materials translated to Spanish, French, or Arabic.

Priorities in Serving SGM Communities.: Agencies varied regarding the degree to which their mission focused specifically on SGM communities. Some agencies provided services that specifically focused on the needs and priorities of SGM communities, including programs to provide resources and support to these communities. Other agencies focused their HIV prevention efforts on other priority populations, such as Black and Latinx cisgender women or people who use injection drugs, but most expressed a commitment to providing a safe and welcoming space that would be inclusive of members of SGM communities. Most agencies did not focus on youth services; however, those that did highlighted inclusion, de-stigmatization, affirmation, and education as priorities in serving SGM youth. One organization specifically cited addressing broader social and economic needs of youth, and others discussed building community and support networks.

Policies and Protocols for Providing Affirming Services to SGM Clients.: Nine agencies (82%) had policies or protocols that were specific for SGM clients. Most agencies reported having a general "non-discrimination" policy codified in their employee handbook or other official document, although several agencies reported that sexual orientation and gender identity were not explicitly protected. Most agencies reported informal policies on respect and fostering an affirming environment for SGM individuals. Several organizations provided gender neutral restrooms, and one organization reported printing staff pronouns on their badges. One organization stated that the agency's mission prioritized the cultivation of an affirming space for SGM youth, and consequently incorporated these policies into all agency activities and services. Most agencies felt that their policies did not need significant changes. However, several agencies supported codifying their commitment to cultivating safe spaces, increasing staff trainings related to serving SGM clients, and expanding recruitment and hiring of individuals with lived experiences and identities that reflect the communities they serve.

Collection of Sexual Orientation and Gender Identity Data.: Agencies varied substantially in the proportion of their clients that identified as sexual minority individuals (i.e., lesbian, gay, bisexual, or queer): two agencies estimated than less than 10% identified as sexual minority individuals, five estimated this proportion to be between 10% and 50%, and four estimated it to be above 50%. Most agencies (n=9) estimated that fewer than 15% of their clients identified as transgender or gender expansive. All but two agencies reported having a system for documenting a client's self-identified name, gender, and pronouns if they differed from the client's legal name and/or sex assigned at birth. Several agencies described logistical complexities related to data collection for insurance purposes and the need to adapt their data management systems to ensure clients' self-identified name, gender, and pronouns were respected. For example, several agencies used systems that enabled staff to highlight a clients' self-identified name and pronouns on paper or electronic medical records.

Outer Setting

Training and Education for Delivering Culturally Humble Care.: Training emerged as a major theme related to the delivery of culturally humble HIV prevention services. Nine agencies reported that staff had received training specifically related to SGM populations. Most agencies reported that these trainings were facilitated by the health department and included HIV-related topics and discussions about pronouns and gender identity. Several agencies also participated in trainings with external educational organizations or reported hosting internal trainings as part of their staff onboarding and continuing education. One agency described an extensive series of internal trainings run through their education department, with all staff, volunteers and contractors completing at least the core curriculum. One agency noted that some trainings from the health department were outdated and conducted by trainers who were not members of the communities they were discussing, which hindered facilitation. They recommended that future trainings be facilitated by individuals who "live and breathe" the content they are teaching.

Funding and Scope of Programs.: The breadth of agency programming for SGM clients varied by agency and was shaped by both internal factors (e.g., agency mission and scope) and external factors (e.g., funding). Generally, agencies recognized the value of programming that was tailored to the needs and priorities of their SGM clients, including services that address social and economic needs and programs that affirm and celebrate diverse identities. Five organizations had programming specifically tailored to SGM youth, including kiki lounges, groups for social support, and youth-focused HIV prevention services. Two organizations had programming specifically for transgender and gender expansive individuals, including providing gender affirming clothing and assistance with name changes and other legal needs. Agencies without SGM-specific programming largely felt that adding this programming would be out of the scope of the agency's mission or not needed because they provide individual-level services rather than group-level programming. Two agencies without SGM programming reported interest in developing small scale programs but noted limited grant support or funding for these activities at their agencies.

Although agencies reported feeling adequately funded to provide HIV prevention services, several expressed frustration that agency programming was limited by a dearth of funding opportunities designed to promote the holistic wellness of SGM clients. Specifically, agencies reported challenges in developing programs that support their clients' economic needs or activities that celebrate local SGM communities but do not directly relate to the provision of HIV prevention services. Multiple agencies reported difficulty securing flexible funding and described efforts to reframe agency goals to support programming that addressed comprehensive health and wellness for SGM communities.

DISCUSSION

Community-based HIV service organizations are well positioned to promote health equity by implementing comprehensive and culturally humble sexual health services. This study explores barriers and facilitators to the implementation of comprehensive and culturally humble sexual health services through a rapid analysis of site assessments at PDPH-funded organizations in Philadelphia. We saw that the needs and priorities identified by agency leadership around providing comprehensive and culturally humble sexual health services were largely parallel to the areas of focus detailed in the city's EHE plan.

Rapid analysis procedures are qualitative research methods that can expedite the collection and interpretation of data to facilitate timely decision making and adaptation when planning and implementing public health programs. Compared with traditional qualitative methods, rapid analysis procedures allow for quick turnaround from identifying key implementation research questions, collecting data from stakeholders, and interpreting data to inform adaptation and action. Additionally, rapid assessment procedures may be beneficial in building and sustaining relationships between research teams and implementation partners. Implementation research that involves multiple partnered institutions and stakeholders may require strategies for data collection that are collaborative, participatory, and responsive to local context.(Holdsworth et al., 2020) We found that by conducting informal interviews, without recording and verbatim transcription, the research team was able to have honest and candid conversations with implementation partners and gain rich insights into the policies

and priorities relevant to providing sexual health services to diverse populations. The use of rapid analysis procedures to continually map agency needs onto public health priorities and evaluate the alignment and responsiveness of these priorities has promise as a strategy that could be applied in EHE jurisdictions nationwide. The findings from this study can inform ongoing efforts to strengthen service delivery for SGM communities by addressing barriers to implementation and highlighting successful organization-level strategies.

Both internal and external factors influenced agencies' efforts to create organizational environments that facilitate the delivery of comprehensive and culturally humble sexual health services. By recruiting and hiring staff members with lived experiences relevant to the SGM clients their organizations served, agencies aimed to deepen their cultural connection and partnership with these communities. Additionally, agencies highlighted the importance of tailored training and education for their staff to increase awareness and knowledge around care needs and priorities for SGM clients. As one agency highlighted, trainings focused on providing services to specific communities (e.g., SGM, Black, Latinx) should be facilitated by individuals who "live and breathe" the content they are teaching. Together, these findings suggest a need for additional investment and development of sustainable training pipelines for comprehensive sexual health service providers that is rooted in partnership between clinical settings and SGM communities. Aligned with this need, the city's strategic plan includes activities to ensure that the HIV workforce is trained and supported to address the specific needs of the populations they serve, including hiring community members with relevant lived experiences and developing and promoting trainings and career development opportunities for frontline staff. Providing resources to complete training programs in HIV test counseling, PrEP navigation, and obtain certification as community health workers and peer-support specialists would create opportunities for individuals from communities disproportionately impacted by HIV to gain new job skills and formalize and recognize their lived expertise. In parallel, this expertise will be critical for designing culturally-responsive SGM health-related programming for all members of the HIV prevention workforce and sustaining partnerships between community and clinical settings. A recent evaluation of a gender-affirming training initiative for health care providers found that trust and partnership with transgender communities and integration of the lived experiences of community members were key determinants of agency readiness to implement new training and education focused on SGM health.(Howson et al., 2021)

Agencies recognized the importance of creating and sustaining programs and services that address the social and economic priorities of their SGM clients and that celebrate diverse identities as an essential component of comprehensive sexual health care. These findings align with the city's focus on supporting agencies to provide culturally humble services for SGM and racial/ethnic minority communities and creating "one-stop shops" for sexual health and related social services. However, agencies noted that to truly create culturally humble wraparound services, additional dedicated funding beyond HIV prevention grants are needed to address structural barriers to care. Given the social and economic oppression often faced by SGM and other marginalized communities, resources for improving access to housing, food security, employment, and education are urgently needed.(Badgett et al., 2019; Gayles et al., 2016) Addressing these structural barriers to health and wellness requires reframing how federal resources are allocated to account for the underlying drivers

of HIV inequities among marginalized communities and focus resources and infrastructure on the communities most impacted by the epidemic.(Friedman et al., 2021) Additional investment is needed from the federal government in the form of greater funding for public housing and other housing assistance programs, expanded job training and job readiness programs that are responsive to the needs of SGM communities, and resources for connecting marginalized communities to debt-free educational opportunities. Federal partners from the Department of Housing and Urban Development, the Department of Labor, and the Department of Education must collaborate with federal health agencies to integrate the resources available through these various programs with ongoing efforts to advance public health and end the HIV epidemic.

Finally, several agencies expressed a need for gender affirming programming. This need is acknowledged in the city's strategic plan through its commitment to supporting gender-affirming and culturally responsive spaces for transgender individuals. To continue to further this commitment, health departments and community-based agencies should work with transgender stakeholders to identify community needs and priorities, including those that may differ from cisgender sexual minority clients, and to create structures to address these needs and priorities as they relate to HIV prevention care. More broadly, additional resources will be needed to provide sexual health services that address the unique priorities identified by transgender clients and community members. Models of gender affirming sexual health services have been developed in partnership with transgender communities that highlight the need for structural interventions (i.e., employment and job skills trainings, housing assistance and referrals, legal services for name and gender marker changes), peer-led programming created by and for the transgender community, and a focus on transgender pride.(Garofalo et al., 2012; Martinez et al., 2019)

One strength of our study is the inclusion of a diverse collection of HIV service organizations with a broad range of missions and clientele. This diversity allows for an investigation of the organizational factors related to the delivery of culturally humble sexual health services in organizations in which serving SGM clients is central to their mission, as well those in which SGM clients are not the primary focus but are among the populations served. Our study also has limitations. First, the CFIR framework was not used in the design of the study or in the data collection instruments; rather, CFIR was used to guide the analysis and interpretation of our results. For this reason, our findings are limited to the constructs that emerged in our qualitative analysis and may not present a complete picture of the determinants of implementation across all CFIR domains. This paper provides a comprehensive inventory of the resources, needs, and priorities related to providing culturally humble HIV services to SGM clients in HIV organizations in Philadelphia; future research should build this foundation by studying specific implementation strategies that could enhance the delivery of culturally humble services to SGM communities. Second, this study is limited only to organizations in Philadelphia that are funded by the PDPH to provide HIV prevention services. Thus, our findings are most applicable to the specific context of funding and may not be generalizable to agencies that are funded privately or through other funding structures. Third, our choice not to capture a verbatim record of conversations during site visits, while serving to foster trust with participating agencies, could potentially hinder the accuracy and completeness of the qualitative data or introduce

bias into the analysis. Fourth, while we collected data about systems for documenting gender identity and pronouns and the gender affirming services offered at each agency, we were limited in our ability to conduct a systematic comparison between services catered specifically to transgender clients and services catered specifically to cisgender sexual minority clients, potentially neglecting the distinct needs and experiences of these two populations. Finally, our findings reflect the perspectives of staff and administrators working in the agencies and do not include information about client experience or perspectives. Future research should integrate the experiences of clients seeking HIV prevention services into assessments of the systems and environment of care.

CONCLUSION

As new HIV prevention modalities become more widely available, such as long-acting injectable PrEP, the need for public health institutions and community-based HIV service organizations to lower structural barriers to care becomes even greater. In Philadelphia, the city's health department has partnered with community stakeholders to develop a robust plan to lower barriers to access, promote equity, and end the HIV epidemic in Philadelphia. The implementation of similar local EHE initiatives can be strengthened by rapid analysis of the barriers and facilitators to implementation of novel programs and service delivery strategies. Studying and addressing systems-level determinants of implementation will support successful and equitable roll-out and scale-up of strategies to achieve EHE targets for reducing new HIV infections and advancing health equity.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1:

Agency level characteristics related to services offered, infrastructure, and accessibility

Agency characteristic	N	%
Type[a]		
Low Threshold Sexual Health Services	4	36.4%
Status Neutral Testing Services	6	54.5%
Community Mobilization	2	18.2%
Syringe Service Program	1	9.1%
Serve >50% sexual minority clients	4	36.4%
Serve >15% transgender clients	2	18.2%
Evening hours	7	63.6%
Weekend hours	4	36.4%
Telehealth services	8	72.7%
On-site phlebotomy	7	63.6%
On-site pharmacy	3	27.3%
Relationship with nearby pharmacy	5	45.5%
Spanish language support	10	90.9%
Support for other languages (not Spanish or English)	3	27.3%
Additional language support	3	27.3%
Telehealth available	8	72.7%
HIV testing on-site	11	100%
Condoms and lubricant available	11	100%
Have HIV Self Testing Kits	10	90.9%
Provide STI testing	7	63.6%
Provide immunizations	5	45.5%
Provide PrEP[b]	7	63.6%
Provide MAT[c]	3	27.3%
Gender affirming services (one or more category of services)	6	54.5%
Gender affirming hormone therapy on-site	3	27.3%
Referral process for gender affirming care	3	27.3%
Use electronic health records	6	54.5%

[a] two organizations were classified as both LTSHS and SNTS

[b] Pre-exposure prophylaxis

[c] Medication assisted treatment for substance use disorders