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HIV EPIDEMIOLOGIC PROFILE

ENDING THE HIV EPIDEMIC

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INFECTIOUS DISEASE BRANCH

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Executive Summary

At the end of 2018, there were 6,070 persons living with HIV Disease (PLWHA) in the State of Arkansas for a rate of 201.4 per 100,000 persons. Of these, 2,659 (44%) were Stage 3 (AIDS) cases and 3,411 (56%) were HIV cases. During 2018, a total of 335 newly diagnosed HIV Disease cases were reported to the HIV Surveillance Program, for an incidence rate of 11.1 per 100,000 persons. The distribution of newly diagnosed cases between HIV and Stage 3 has been stable since 2014. Of the 335 newly diagnosed cases, 120 (36%) were Stage 3 (AIDS) cases and 215 (64%) were HIV cases.

HIV Disease is disproportionately distributed across Arkansas' population. Non-Hispanic (NH) -Blacks were more likely to be newly diagnosed than any other racial/ethnic group. Blacks accounted for 55.8% of all new HIV Disease diagnoses. Male-to-Male sexual contact was the most common known mode of transmission, followed by high-risk heterosexual transmission. These patterns are congruent with national statistics. The most impacted age groups in 2018 were 25-34 years old, with 122 (36.4%) newly diagnosed cases, and 15-24 year olds with 80 (23.9%) newly diagnosed cases. The number of new diagnoses among youth aged 15-25 has been stable since 2015 in Arkansas. CDC recently reported that approximately 21% of new HIV diagnoses in the United States and dependent areas were amongst youth.

The state of Arkansas is divided into five (5) public health regions. The Central region is located in the geographic center of the state and includes seven counties as well as the state capital, Little Rock. In 2018, the county in the Central region with the highest newly reported cases was Pulaski (120). The Northeast region, which borders the state of Tennessee, makes up part of the Memphis Transitional Grant Area (TGA). It consists of 18 counties, including the Jonesboro area where Arkansas State University is located. The county in the Northeast region with the highest newly reported cases was Crittenden (14). The Northwest region which borders Oklahoma on the west and Missouri to the north is comprised of 19 counties, and includes the Fort Smith, Fayetteville-Springdale-Rogers, and Bentonville metropolitan areas. Also located in this region are the University of Arkansas and the headquarters for Wal-Mart, J. B. Hunt, and Tyson. This region is arguably the most economically advantaged area of the state. This region holds the largest percentage of Hispanics in the state; and many Marshallese have also made the Northwest their home. The county in the Northwest region with the highest newly reported cases was Washington (20). The Southeast region includes 14 counties. This region is dominated by the most economically deprived area of the state, known as the Mississippi Delta. The county in the Southeast region with the highest newly reported cases was Jefferson (8). The Southwest region consists of 17 counties in the lower portion of the state bordering Oklahoma, Texas and Louisiana. Included in this area is the bi-state city of Texarkana. The county in the Southeast region with the highest newly reported cases was Hot Springs (15).

The Arkansas Department of Health (ADH) and statewide partners are committed to expansion of HIV efforts for utilizing data for increasing resources for HIV testing, prevention, and treatment.

Introduction

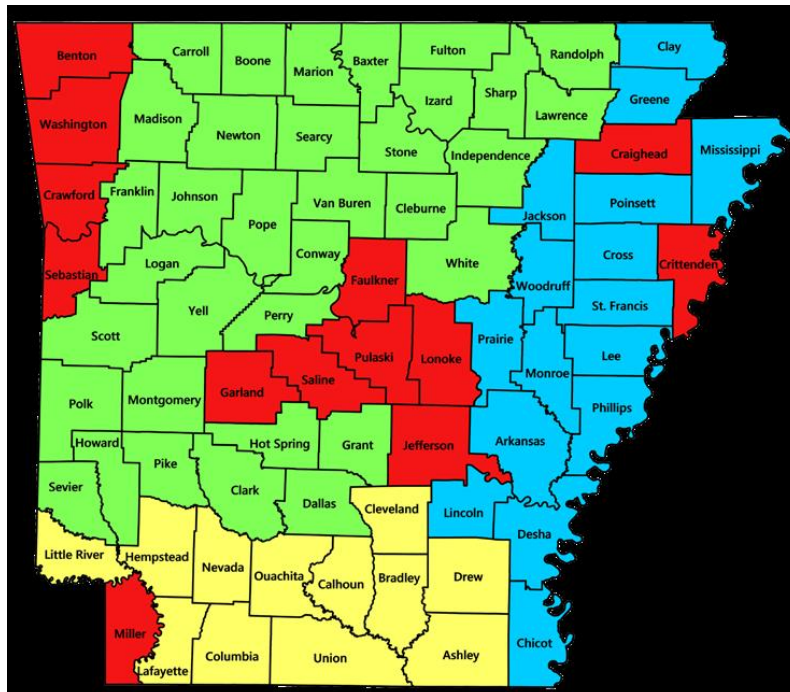
Welcome to Arkansas! The “Natural State”

This epidemiologic profile for Arkansas utilizes published information from the University of Arkansas, Division of Agriculture- Research and Extension Office’s “2019 Rural Profile of Arkansas”. The published document illustrates the characteristics of society, economy, and regions of the state based upon data-driven analysis over the period of 2010-2017.

The overarching characteristic from the analysis of all data collected for the profile, draws the conclusion that “Arkansas is a very rural state” (Miller & Knapp, 2019). Since the 1900s, the percentage of people in Arkansas living in rural areas has been higher than the nation’s. The 2010 Census outlined 19% of the United States population was rural compared with 44% for Arkansans.

Figure 1. Illustrates how regions of the state are depicted as rural or urban. In addition, the rural regions of the state are further classified as either Coastal Plains, Delta, or Highlands.

Figure 1. Arkansas Regions and Counties



Coastal Plains (Rural)
 Delta (Rural)

 Highlands (Rural)
 Urban

2019 Rural Profile of Arkansas. (2019). Retrieved October 12, 2020, from <https://www.uaex.edu/business-communities/economic-development/rural-profile-of-arkansas.aspx>

Data Sources

Data were compiled from a variety of sources to provide the most complete picture of the epidemic in Arkansas. When interpreting the data, keep in mind that each of the data sources has strengths and limitations. A brief description of each data source is provided below.

Arkansas Department of Health

Core HIV Disease Surveillance

The Arkansas Department of Health (ADH) began conducting HIV/AIDS surveillance in 1983. On July 1, 1999, the Arkansas statutes requiring confidential name-based HIV reporting were instituted. All HIV and Stage 3 (AIDS) cases diagnosed or treated in the State of Arkansas are reportable to the Arkansas Department of Health's HIV/AIDS Surveillance Program. Standardized case report forms are used to collect demographics, vital status, laboratory and clinical results, as well as risk factor information on all cases. All surveillance data are entered into the HIV/AIDS Reporting System (eHARS), the standardized database developed by CDC.

Limitations: HIV Surveillance data can provide only a minimum of estimates of the number of persons known to be infected with the condition. HIV Disease surveillance is totally reliant on positive laboratory test results and the fulfillment of disease reporting requirements by providers and laboratories.

Ryan White Part B Program

The Ryan White Part B Program in the State of Arkansas has been assisting Arkansans living with HIV and Stage 3 (AIDS) via a variety of resources since 1991, after the enactment of the Federal Comprehensive AIDS Resources Emergency (CARE) Act in 1990. The Ryan White CARE Act (RWCA) ensures quality and availability of care for medically underserved individuals and families affected by HIV Disease. The Ryan White Part B Program in Arkansas maintains a database within the Infectious Disease Branch at ADH. Data collected include client demographics, diagnostic status, financial eligibility and vital status information.

Limitations: Data are collected only from clients who know their HIV status and who are eligible for Ryan White services.

AIDS Drug Assistance Program (ADAP)

The ADAP is a state administered program located within the Arkansas Department of Health's Infectious Disease Branch that provides medications free of charge to persons living with HIV Disease who meet program eligibility requirements.

Limitations: The data is not generalizable to all HIV infected persons in Arkansas because data is only collected on persons who know their HIV status. Clients in ADAP are eligible to receive care /

treatment services through the Ryan White Part B Program or are financially eligible to receive ADAP services because of partial medication coverage through public or private insurance.

Sexually Transmitted Infectious Disease (STI) Surveillance

The Arkansas Department of Health STI Program conducts statewide surveillance of chlamydia, gonorrhea and syphilis infections. Services provided include partner counseling, referral services and treatment. Data are collected in the Patient Reporting Investigation Surveillance Manager System (PRISM). These data can serve as a surrogate marker for unsafe sexual practices and demonstrate the prevalence of changes in specific behaviors.

Limitations: The data is dependent upon compliance with reporting laws and is limited to positive test results. Other common STIs, such as human papillomavirus (HPV) and herpes simplex virus (HSV) are not notifiable diseases. Additionally, STIs are often asymptomatic and may not be diagnosed; therefore, case report data underestimate the number of infections that occurred.

Health Statistics Data

The Vital Records Branch collects information on all births and deaths that occur in the State of Arkansas. A Cause of Death query was performed on the publicly available Arkansas Center for Health Statistics Query System, at <http://www.healthy.arkansas.gov/programsServices/healthStatistics>.

The yearly numbers and rates of HIV-associated deaths occurring in Arkansas were determined for 1990 to 2015, using ICD-10 diagnosis codes for HIV (B20–B24).

Limitations: Deaths resulting from HIV or with HIV as an underlying cause may be underreported on death certificates. Death records are less timely than Stage 3 (AIDS) case reports. Notably, in 1999 a new cause-of-death tabulation was developed in the form of ICD-10 (International Classification of Diseases) codes. Before 1999, the ICD-9 classification was used. There are differences in mortality rates between the two codes. In this document, no adjustments have been made in mortality rates with respect to ICD-9 and ICD-10 codes.

Population and Sociodemographic Data

University of Arkansas Division of Agriculture: Research & Extension

The research of the University of Arkansas System Division of Agriculture, provided information and data regarding the social, demographic, and economic profile of conditions in rural and urban regions of the state. This profile, in one form or the other, has been providing information for more than 20 years and has served as a valued source of data and information for elected leaders in the state as well as for local government stakeholders and public servants. The profile is designed to be a tool for leaders in planning and directing policies and programs to enhance the well-being of all Arkansans.

Limitations: While the major focus of the profile remains on understanding the differences between rural and urban areas of the state, conditions also vary within the rural areas. To provide insight into

how circumstances differ in rural areas, three distinct regions – the Delta, the Coastal Plains and the Highlands – were studied.

Socio-demographics

The 2010 Census reported the population of Arkansas at 2,926,229. The population of Arkansas grew by 2.8% between 2010 and 2017, a little more than half the 5.3% growth rate nationally (Miller & Knapp, 2019). However, this increase represents nearly 83,000 new residents in the state. Despite the moderate population growth statewide, the trend seen in the 2000s-loss of population from rural regions to the Urban region-continued into the 2010s (Miller & Knapp, 2019).

Population Trends

The population in the rural regions decreased 2.5% between 2010 and 2017. While there was some variation among the rural regions, the population of each decreased over the seven-year period. Population in the Delta decreased 5.7%, followed closely by the Coastal Plains at 5.3%. The population of the Highlands decreased by about 0.5% (Miller & Knapp, 2019).

Age

The proportion of Arkansas' population 65 years of age and older was growing and becoming a larger share of the total population between 2010 and 2017. It grew 19% during this seven-year period. Slightly more than 19% of the population living in rural counties were 65 years of age and older compared to about 15% in urban counties (Miller & Knapp, 2019).

The median age of Arkansans (38.1 years) was similar to the national median age (38 years) in 2017 and both increased slightly from 2010 to 2017. Not surprisingly, the Highlands region which has a larger share of its population age 65 and older, has a substantially higher median age than other regions in the state. The average median age of the Highlands region was 43.5 years of age in 2017 compared to 41.8 years of age in the Coastal Plains and 41.2 years of age in the Delta (Miller & Knapp, 2019).

Race and Ethnicity

Racial and ethnic diversity in Arkansas, both in terms of the number and share of the population, increased somewhat from 2010 to 2017. The non-white population increased 8.2% compared to 1.5% growth in the white population during this seven-year period. Most of the growth in the non-white population occurred in the urban area. However, during this time period in the rural region, the three classified areas showed the following (Miller & Knapp, 2019):

- the Highlands experienced the highest percentage growth (14.3%) in its non-white population, and
- both the Delta and Coastal Plains lost non-white population from 2010 to 2017.

The Hispanic population also grew statewide and in both rural and urban areas of the state from 2010 to 2017. Statewide the Hispanic population grew by over 40,000 or 21.5% during this period. Nearly three-fourths of this growth was in the Urban region. Rural areas experienced growth in their Hispanic population of a little over 10,000 or 18.5%. Statewide, the share of the Hispanic population grew from 6.4% of the total population in 2010 to 7.6% in 2017. The share of the Hispanic population in the Urban region was 9.1% in 2017 compared to only 5.4% in the rural region (Miller & Knapp, 2019).

Education

People are Arkansas' greatest resource and the social and economic value of a well-educated population cannot be overstated. Investing in education provides a more skilled work force, lowers poverty rates and creates the ability to participate in civil society, which benefits the individual, communities, and the state. To maintain and improve the state's human capital, improving access to high-quality education from pre-kindergarten to community college and beyond is critical (Miller & Knapp, 2019).

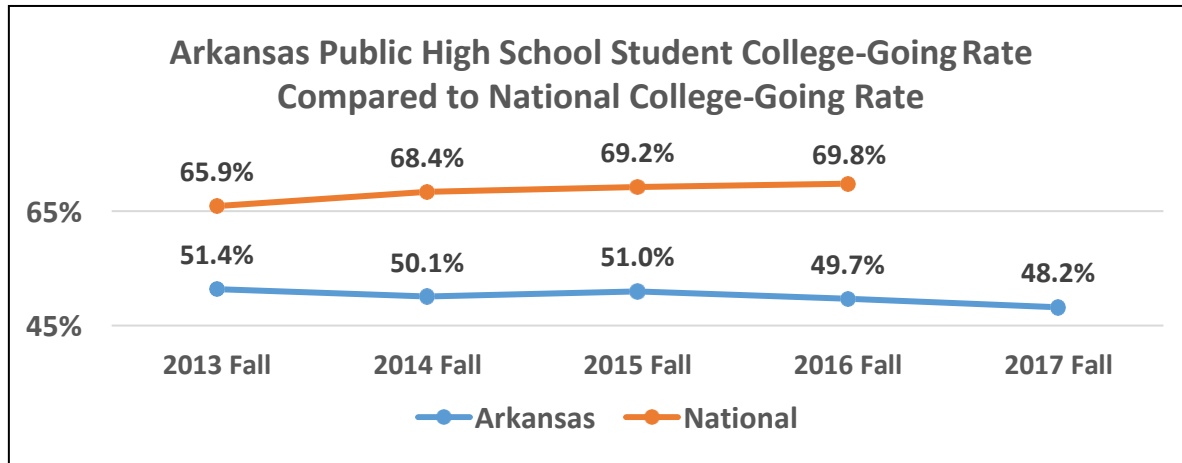
Educational attainment levels in Arkansas continued to grow slowly, but remained well below the national average in 2016. There also remains a wide divide in educational attainment between the rural and urban areas of the state. While most agree that high quality education is critical for individual well-being and for the state to remain competitive in a global economy, the rural communities of Arkansas struggle to provide STEM (science, technology, engineering & math) educational services (Miller & Knapp, 2019).

Fifty-two of the 62 rural counties and four urban counties had declining K-12 enrollment from 2007-08 to 2017-18. All counties in the Delta and Coastal Plains, except for Greene and Columbia, had declining school enrollments during this period. Six rural counties lost 20% or more of their public school enrollment. To overcome shrinking population, decreased funding, and rising costs, public school districts are often forced to consolidate into large school districts. While there may be efficiency gains and more educational opportunities for students, there are also costs in school consolidation. Such decisions often burden students who must be bused long distances to attend school and strain rural communities due to job loss. School consolidation may also result in the loss of identity for small communities as, historically, the local school often serves as a gathering place and site of social interactions for the entire community (Miller & Knapp, 2019).

The public high school student college-going rate (CGR) for all Arkansas public and independent institutions for the 2017 Fall term was 48.2 percent. This represents a decrease of 1.5 percentage points from the previous fall term (ADE, 2018).

* The College-Going Rate (CGR) is defined as the percentage of Arkansas public high school students who completed high school in a given year and subsequently enrolled in any public or private postsecondary institution (in-state or out-of-state) in the United States within 12 or 16 months of completing high school.

Figure 2. Arkansas Public High School Student College-Going Rate Compared to National College-Going Rate



Arkansas experienced a 3.2% decrease (from 51.4% to 48.2%) in the College-Going Rate of public high school graduates over the past five years (ADE, 2018).

Table 1.

Term	Public HS Graduates	Those Entering College	CGR
2013 Fall	29,714	15,263	51.4%
2014 Fall	30,800	15,419	50.1%
2015 Fall	30,370	15,479	51.0%
2016 Fall	30,152	14,984	49.7%
2017 Fall	31,315	15,094	48.2%

In 2017, of all the CGR students graduating from a public high school, the majority enrolled in a public 4-year university. Figure-4 (below) illustrates the CGR by Institution type. In the state of Arkansas, females go to college at higher rates than males. In 2017, 42.3% of males attended college versus 54.0% of females. In addition, the White and Asian student populations have highest college-going rates, see Table 2 (ADE, 2018). For the state of Arkansas, rural areas had a higher college-going enrollment rate; however, this did not translate into higher rates of educational attainment for rural citizens (Miller & Knapp, 2019). The ability of state and local leaders to improve educational services in rural communities will be critical for Arkansas’ continued growth (Miller & Knapp, 2019).

Figure 3. 2017 Fall CGR by Institution Type

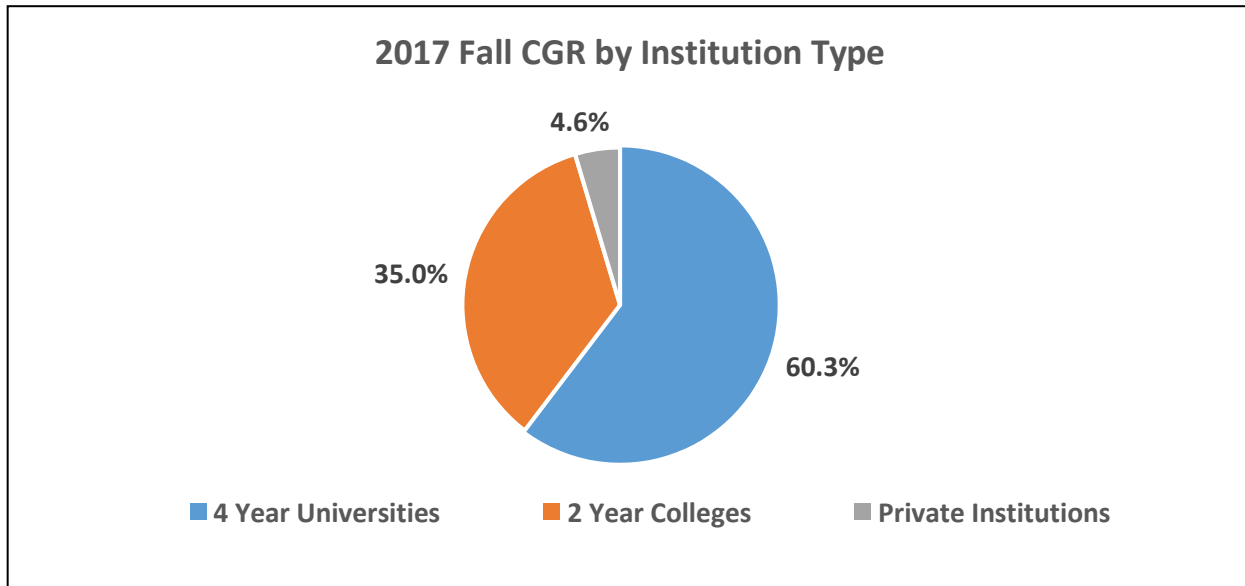


Table 2. College-Going Rates amongst Race/Ethnicity

Race/Ethnicity	2016-17 HS Graduates	College Going Rate	
		First-Time Students	Percent
Asian	550	295	53.6%
Black/African American	6,332	2,554	40.3%
Hispanic	3,375	1,334	39.5%
Native American/Alaskan Native	229	103	45.0%
Native Hawaiian/Pacific Islander	146	16	11.0%
Two or More Races	510	249	48.8%
White	20,173	10,541	52.3%

Economy

While the Arkansas economy has grown since 2010 (see Figure 5 below), there continues to be a big difference in the growth/decline between the urban and rural economies in the state from 2010 to 2016. Most urban areas of the state, with notable exceptions of Jefferson, Sebastian, and Crawford counties, experienced a smaller decline in employment during the recession and a larger increase during the post-recession recovery. Employment declined by 2.2% in urban areas from 2007 to 2010 compared to 3.5% in rural areas. During the post-recession recovery from 2010 to 2016, employment in urban areas increased 9.1% compared to a slight increase of 0.3% in rural areas of the state. While the Urban region of the state experienced an increase in total employment of 6.7% from 2007 to 2016, the rural region has not recovered from the recession and has yet to reach pre-recession employment levels. Employment in the rural region of the state was 3.2% less in 2016 than 2007 (Miller & Knapp, 2019).

Diversity in type of industry and sources of income is vital to success of Arkansas' economy. While the natural resources (Farm & Forestry and Mining) and manufacturing sectors are critical to the state's economy, the service sector provided the largest share of employment in both urban and rural regions in 2016. The major structural difference between rural and urban economies was that the manufacturing and natural resources sectors provided a larger share of employment in the rural region, whereas the service sector employed a larger share of workers in the urban region (Figure 6). In 2016, nearly 25% of jobs in the rural region were Farm & Forestry, Mining, and Manufacturing, compared to approximately 10% in the urban region. The urban region had 42% of its jobs in the Professional and Other Services sectors compared to just 32% in the rural region (Miller & Knapp, 2019).

Income

The average earnings per job in Arkansas in 2016 was approximately 78% of the national average: \$45,217 in Arkansas compared to \$58,372 nationwide. The average earnings per job in Arkansas increased 3.6% from 2010 to 2016, while the national average earnings per job increased 2.2%. However, the increase in the average earnings per job from pre-recession levels in Arkansas was less than two percent (1.9%) due to a decline in average earnings per job from 2007 to 2010 (Figure 7) (Miller & Knapp, 2019).

Although average earnings per job increased at a faster rate in the rural region of Arkansas from 2010 to 2016, it remains below pre-recession highs and there remains a persistent gap between rural and urban earnings per job. Average earnings per job in the rural region increased 3.7% from 2010 to 2016 compared to an increase of 1.9% in the Urban region. This resulted in average earnings per job in the rural region growing from 83.5% to 85% of that in the Urban region during this six-year period, but remained below the pre-recession level of approximately 87% (Miller & Knapp, 2019).

The median household income in Arkansas was \$42,336 in 2016, which was approximately 77% of the median household income in the nation. Five-year estimates from 2006-2010 to 2012-2016 indicated that median household income in Arkansas declined 2% during this six-year period. The average median household income of counties in the rural region of the state was only 78% of the average median household income of counties in the Urban region and 65% of U.S. median household

income. In 2016, the average median household income of counties in the rural region was approximately \$36,000 compared to \$46,000 in the Urban region (Miller & Knapp, 2019).

Although average earnings per job increased between 2010 and 2016, there were fewer jobs in rural areas of the state and many rural households had low and declining household incomes (Miller & Knapp, 2019).

Infrastructure

Infrastructure is the backbone of Arkansas' economy. Access to modern infrastructure connects people and businesses to world markets and information, and improves the overall quality of life. In contrast, limited access to infrastructure-due to low quality or quantity- may prolong poverty and slow economic development (Miller & Knapp, 2019). Two key areas of infrastructure in the state that impacts and limits the continued growth and expansion of public health initiatives are transportation and access to high speed internet.

Transportation

At the end of 2017, the Arkansas Transportation Department through its Interstate Rehabilitation Program (IRP) is expected to complete \$1 billion in construction projects of the state's highways. The program includes 82 road projects and at the close of 2017, 36 IRP projects had been completed on 223 miles of highway. Nine projects were under construction for an additional 76 miles of highway, and 32 other future projects still remained for construction which would add 190 more miles of highway improvement.

However, despite improvements to the major highways, the state does not have a statewide transit system. The Urban regions of the state have eight bus transit services, taxi services, and rideshare services (Uber and/or Lyft). The rural region has nine bus transit services servicing certain counties; however the state's transportation in majority of the Coastal Plains, Highlands, and Delta is limited to persons having to secure their own modes of transportation. For many persons in rural areas, due to low incomes of residents, there is a large amount of persons without access to a vehicle for transportation. Even though the rural and urban areas have transits for certain counties, the transit is often limited to the areas it services. Therefore, if specific resources are not available in the transit's service's areas of operation, residents must find other travel accommodations or resources for their specific need.

Internet

The access to high speed broadband remains low in Arkansas. It was estimated that only between 400 to 600 households of every 1,000 in Arkansas have access to an internet speed of 0.2 megabits per second (Mbps) in 2015. It was estimated that only 200 to 400 of every 1,000 households in Arkansas had access to internet with download speeds of at least 10 Mbps in 2015. While internet with below standard speeds appears to be the norm in Arkansas, rural counties are disproportionately impacted by substandard internet access (Figure 9) (Miller & Knapp, 2019).

Health

Infant mortality rates (IMR) and obesity levels are broad measures of the health of Arkansans. Arkansas ranked third highest among all states for IMR; and obesity continues to be an epidemic in the United States, and Arkansas is no exception in both rural and urban areas (Miller & Knapp, 2019). Figure 10 and Figure 11 below show county health rankings for “health factors” and “health outcomes”.

Health factor scores represent behaviors that affect how long and how well persons live. The higher the number, the better the behavioral factors that affect the health of the population. In general, the population in the Urban region of the state had more healthy behaviors than in the rural region. However, there is considerable variation among counties within regions of the state (Miller & Knapp, 2019).

The average index value in urban counties was 0.35 and -0.07 in rural counties. The negative numbers indicate that these counties ranked below the statewide average, whereas positive numbers indicate values above that average. Five of the seven counties with health factor scores of 0.5 or higher were urban counties. The rural region areas illustrated the following: (Miller & Knapp, 2019)

- Delta counties had some of the lowest scores with seven of the Delta counties having scores of -0.5 or below.
- Crittenden county, an Urban region located in the Delta area, also had a score of less than -0.5.
- Boone and Baxter counties in the Highlands were the only two rural counties with scores above 0.5.
- Four of the thirteen Coastal Plains counties had scores within the 0 to 0.5 range.

The “health outcome” scores measures length and quality of life. Research clearly illustrates that the Delta and many of the Coastal Plains counties had low health outcomes compared to other areas of the state. Both the highlands and urban counties had higher health outcomes; however, the two urban counties of Crittenden and Jefferson were the exception to this generalization. The rural highlands area of the state had 74% of counties with health outcome scores above zero (Miller & Knapp, 2019).

In 2010, through the provisions of the Affordable Care Act (ACA), the state of Arkansas expanded its Medicaid program. Arkansas led the nation in implementing an alternative to Medicaid expansion that was acceptable to some politicians who otherwise opposed the ACA. Arkansas’ Medicaid expansion program was initially called the Arkansas Health Care Independence Program, but transitioned to Arkansas Works as of 2017. Both systems are also referred to as the “Private Option”, because Arkansas uses Medicaid funds to purchase private health insurance in the exchange for people who are eligible for expanded Medicaid. Enrollees can pick from available silver plans in their area and the Arkansas Medicaid pays the premiums.

To be eligible, persons needing assistance with obtaining health insurance coverage must meet the

following levels:

- Children from birth to age 18 with incomes up to 211 percent of FPL
- Pregnant women with incomes up to 209 percent FPL
- Parents with incomes up to 138 percent FPL
- Non-elderly adults with incomes up to 138 percent
- Elderly and disabled individuals

According to the Arkansas Center for Health Improvement (ACHI), currently in the state of Arkansas the breakdown of medical insurance coverages is: (Brawner, 2020)

- Private Insurance: 1.2 million
- Traditional Medicaid (includes ARKids-A): 720,000
- ARKids-B (requires a copay): 33,000
- Medicare: 646,000
- Arkansas Works: 261,975
- Arkansas Health Insurance Marketplace: 59,319
- Uninsured: 300,000

Newly Diagnosed Persons in Arkansas: 2018

In 2018, 335 persons were newly diagnosed with HIV in Arkansas. Of the reported 335 cases, 68 (20.3%) were female and 267 (79.7%) were male. The Black population accounted for more than half (55.8%) of the newly reported cases, compared to the White (34.3%) and Hispanic (7.8%) populations within the state. The 25-34 year old age group was the highest with 122 (36.4%) reported cases, followed by the 15-24 year old age group with 80 (23.9%) of the reported cases. Throughout all regions, male to male sexual contact was the highest reported exposure category at 59.1%.

Central

The state of Arkansas is divided into five (5) public health regions. The Central region is located in the geographic center of the state and includes seven counties as well as the state capital, Little Rock.

The county in the Central region with the highest newly reported cases was Pulaski (120).

	Stage 3 (AIDS) New Cases**		HIV New Cases***		HIV Disease New Cases+	
	Jan-Dec 2018		Jan-Dec 2018		Jan-Dec 2018	
Gender	Number	Percent	Number	Percent	Number	Percent
Female	12	21.8%	15	13.5%	27	16.3%
Male	43	78.2%	96	86.5%	139	83.7%
Unknown	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Total	55	100.0%	111	100.0%	166	100.0%
Race/Ethnicity	Number	Percent	Number	Percent	Number	Percent
White, non-Hispanic	12	21.8%	35	31.5%	47	28.3%
Black, non-Hispanic	35	63.6%	68	61.3%	103	62.0%
Am Indian/AK Native, non-Hispanic	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Asian/HI/Pacific Islander, non-Hispanic	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Hispanic	7	12.7%	7	6.3%	14	8.4%
Other, non-Hispanic	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Unknown	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Total	55	100.0%	111	100.0%	166	100.0%
Age at Diagnosis	Number	Percent	Number	Percent	Number	Percent
<13	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
13-14	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
15-24	6	10.9%	37	33.3%	43	25.9%
25-34	26	47.3%	42	37.8%	68	41.0%
35-44	14	25.5%	17	15.3%	31	18.7%
45-54	6	10.9%	11	9.9%	17	10.2%
55-64	<5*	5.5%	<5*	<5.0%*	6	<5.0%*
65+	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Unknown	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Total	55	100.0%	<5*	<5.0%*	<5*	<5.0%*
Exposure Category	Number	Percent	Number	Percent	Number	Percent

Male Sex w/ Male (MSM)	36	65.5%	74	66.7%	110	66.3%
Injection Drug Use (IDU)	<5*	<5.0%*	6	5.4%	7	<5.0%*
MSM & IDU	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
High-risk Heterosexual	8	14.5%	13	11.7%	21	12.7%
Transfusion/Hemophiliac	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Perinatal Exposure	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
No Identified/Reported Risk	8	14.5%	17	15.3%	25	15.1%
Total	55	100.0%	111	100.0%	166	100.0%

Note: Due to rounding, percentages may not add up to 100.

* Cell sizes less than 5 cannot be reported.

** Stage 3 (AIDS) New Cases: the number of new AIDS cases diagnosed as of December 31, 2018. This includes persons originally diagnosed as HIV (stages 0, 1 or 2) who progressed to AIDS during the year.

*** HIV New Cases: the number of new HIV (stages 0, 1 or 2) cases diagnosed as of December 31, 2018.

+ HIV Disease New Cases: the sum of the new HIV (stages 0, 1 or 2) cases and new AIDS cases diagnosed as of December 31, 2018.

Northeast

The Northeast region, which borders the state of Tennessee, makes up part of the Memphis Transitional Grant Area (TGA). It consists of 18 counties, including the Jonesboro area where Arkansas State University is located. The county in the Northeast region with the highest newly reported cases was Crittenden (14).

	Stage 3 (AIDS) New Cases**		HIV New Cases***		HIV Disease New Cases+	
	Jan-Dec 2018		Jan-Dec 2018		Jan-Dec 2018	
Gender	Number	Percent	Number	Percent	Number	Percent
Female	7	35.0%	6	16.7%	13	23.2%
Male	13	65.0%	30	83.3%	43	76.8%
Unknown	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Total	20	100.0%	36	100.0%	56	100.0%
Race/Ethnicity	Number	Percent	Number	Percent	Number	Percent
White, non-Hispanic	7	35.0%	14	38.9%	21	37.5%
Black, non-Hispanic	12	60.0%	19	52.8%	31	55.4%
Am Indian/AK Native, non-Hispanic	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Asian/HI/Pacific Islander, non-Hispanic	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Hispanic	<5*	5.0%	<5*	8.3%	<5*	7.1%
Other, non-Hispanic	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Unknown	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Total	20	100.0%	36	100.0%	56	100.0%
Age at Diagnosis	Number	Percent	Number	Percent	Number	Percent
<13	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
13-14	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
15-24	<5*	10.0%	12	33.3%	14	25.0%

25-34	9	45.0%	13	36.1%	22	39.3%
35-44	<5*	10.0%	<5*	13.9%	7	12.5%
45-54	6	30.0%	<5*	8.3%	9	16.1%
55-64	<5*	5.0%	<5*	<5.0%*	<5*	<5.0%*
65+	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Unknown	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Total	20	100.0%	36	100.0%	56	100.0%
Exposure Category	Number	Percent	Number	Percent	Number	Percent
Male Sex w/ Male (MSM)	9	45.0%	24	66.7%	33	58.9%
Injection Drug Use (IDU)	<5*	5.0%	<5*	5.6%	<5*	5.4%
MSM & IDU	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
High-risk Heterosexual	6	30.0%	8	22.2%	14	25.0%
Transfusion/Hemophiliac	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Perinatal Exposure	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
No Identified/Reported Risk	<5*	20.0%	<5*	<5.0%*	<5*	8.9%
Total	20	100.0%	36	100.0%	56	100.0%

Note: Due to rounding, percentages may not add up to 100.

* Cell sizes less than 5 cannot be reported.

** Stage 3 (AIDS) New Cases: the number of new AIDS cases diagnosed as of December 31, 2018. This includes persons originally diagnosed as HIV (stages 0, 1 or 2) who progressed to AIDS during the year.

*** HIV New Cases: the number of new HIV (stages 0, 1 or 2) cases diagnosed as of December 31, 2018.

+ HIV Disease New Cases: the sum of the new HIV (stages 0, 1 or 2) cases and new AIDS cases diagnosed as of December 31, 2018.

Northwest

The Northwest region which borders Oklahoma on the west and Missouri to the north is comprised of 19 counties, and includes the Fort Smith, Fayetteville-Springdale-Rogers, and Bentonville metropolitan areas. Also located in this region are the University of Arkansas and the headquarters for Wal-Mart, J. B. Hunt, and Tyson. This region is arguably the most economically advantaged area of the state. This region holds the largest percentage of Hispanics in the state; and many Marshallese have also made the Northwest their home. The county in the Northwest region with the highest newly reported cases was Washington (20).

	Stage 3 (AIDS) New Cases**		HIV New Cases***		HIV Disease New Cases+	
	Jan–Dec 2018		Jan–Dec 2018		Jan–Dec 2018	
Gender	Number	Percent	Number	Percent	Number	Percent
Female	6	30.0%	9	29.0%	15	29.4%
Male	14	70.0%	22	71.0%	36	70.6%
Unknown	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Total	20	100.0%	31	100.0%	51	100.0%
Race/Ethnicity	Number	Percent	Number	Percent	Number	Percent

White, non-Hispanic	10	50.0%	14	45.2%	24	47.1%
Black, non-Hispanic	6	30.0%	9	29.0%	15	29.4%
Am Indian/AK Native, non-Hispanic	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Asian/HI/Pacific Islander, non-Hispanic	<5*	5.0%	<5*	6.5%	<5*	5.9%
Hispanic	<5*	10.0%	6	19.4%	8	15.7%
Other, non-Hispanic	<5*	5.0%	<5*	<5.0%*	<5*	<5.0%*
Unknown	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Total	20	100.0%	31	100.0%	51	100.0%
Age at Diagnosis	Number	Percent	Number	Percent	Number	Percent
<13	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
13-14	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
15-24	<5*	10.0%	8	25.8%	10	19.6%
25-34	<5*	15.0%	10	32.3%	13	25.5%
35-44	<5*	15.0%	<5*	9.7%	6	11.8%
45-54	7	35.0%	5	16.1%	12	23.55
55-64	<5*	20.0%	<5*	9.7%	7	13.7%
65+	<5*	5.0%	<5*	<5.0%*	<5*	<5.0%*
Unknown	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Total	20	100.0%	31	100.0%	51	100.0%
Exposure Category	Number	Percent	Number	Percent	Number	Percent
Male Sex w/ Male (MSM)	11	55.0%	16	51.6%	27	52.9%
Injection Drug Use (IDU)	<5*	5.0%	<5*	6.5%	<5*	5.9%
MSM & IDU	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
High-risk Heterosexual	7	35.0%	6	19.4%	13	25.5%
Transfusion/Hemophiliac	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Perinatal Exposure	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
No Identified/Reported Risk	<5*	5.0%	6	19.4%	7	13.7%
Total	20	100.0%	31	100.0%	51	100.0%

Note: Due to rounding, percentages may not add up to 100.

* Cell sizes less than 5 cannot be reported.

** Stage 3 (AIDS) New Cases: the number of new AIDS cases diagnosed as of December 31, 2018. This includes persons originally diagnosed as HIV (stages 0, 1 or 2) who progressed to AIDS during the year.

*** HIV New Cases: the number of new HIV (stages 0, 1 or 2) cases diagnosed as of December 31, 2018.

+ HIV Disease New Cases: the sum of the new HIV (stages 0, 1 or 2) cases and new AIDS cases diagnosed as of December 31, 2018.

Southeast

The Southeast region includes 14 counties. This region is dominated by the most economically deprived area of the state, known as the Mississippi Delta. The county in the Southeast region with the highest newly reported cases was Jefferson (8).

	Stage 3 (AIDS) New Cases**		HIV New Cases***		HIV Disease New Cases+	
	Jan–Dec 2018		Jan–Dec 2018		Jan–Dec 2018	
Gender	Number	Percent	Number	Percent	Number	Percent
Female	<5*	7.1%	5	31.3%	6	20.0%
Male	13	92.9%	11	68.8%	24	80.0%
Unknown	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Total	14	100.0%	16	100.0%	30	100.0%
Race/Ethnicity	Number	Percent	Number	Percent	Number	Percent
White, non-Hispanic	5	35.7%	<5*	25.0%	9	30.0%
Black, non-Hispanic	9	64.3%	12	75.0%	21	70.0%
Am Indian/AK Native, non-Hispanic	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Asian/HI/Pacific Islander, non-Hispanic	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Hispanic	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Other, non-Hispanic	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Unknown	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Total	14	100.0%	16	100.0%	30	100.0%
Age at Diagnosis	Number	Percent	Number	Percent	Number	Percent
<13	<5*	<5.0%*	<5*	6.3%	<5*	<5.0%*
13-14	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
15-24	<5*	14.3%	6	37.5%	8	26.7%
25-34	<5*	21.4%	6	37.5%	9	30.0%
35-44	<5*	7.1%	<5*	12.5%	<5*	10.0%
45-54	6	42.9%	<5*	6.3%	7	23.3%
55-64	<5*	7.1%	<5*	<5.0%*	<5*	<5.0%*
65+	<5*	7.1%	<5*	<5.0%*	<5*	<5.0%*
Unknown	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Total	14	100.0%	16	100.0%	30	100.0%
Exposure Category	Number	Percent	Number	Percent	Number	Percent
Male Sex w/ Male (MSM)	9	64.3%	8	50.0%	17	56.7%
Injection Drug Use (IDU)	<5*	14.3%	<5*	6.3%	<5*	10.0%
MSM & IDU	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
High-risk Heterosexual	<5*	14.3%	<5*	25.0%	6	20.0%
Transfusion/Hemophiliac	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Perinatal Exposure	<5*	<5.0%*	<5*	6.3%	<5*	<5.0%*
No Identified/Reported Risk	<5*	7.1%	<5*	12.5%	<5*	10.0%
Total	14	100.0%	16	100.0%	30	100.0%

Note: Due to rounding, percentages may not add up to 100.

* Cell sizes less than 5 cannot be reported.

** Stage 3 (AIDS) New Cases: the number of new AIDS cases diagnosed as of December 31, 2018. This includes persons originally diagnosed as HIV (stages 0, 1 or 2) who progressed to AIDS during the year.

*** HIV New Cases: the number of new HIV (stages 0, 1 or 2) cases diagnosed as of December 31, 2018.

+ HIV Disease New Cases: the sum of the new HIV (stages 0, 1 or 2) cases and new AIDS cases diagnosed as of December 31, 2018.

Southwest

The Southwest region consists of 17 counties in the lower portion of the state bordering Oklahoma, Texas and Louisiana. Included in this area is the bi-state city of Texarkana. The county in the Southeast region with the highest newly reported cases was Hot Springs (15).

	Stage 3 (AIDS) New Cases**		HIV New Cases***		HIV Disease New Cases+	
	Jan-Dec 2018		Jan-Dec 2018		Jan-Dec 2018	
Gender	Number	Percent	Number	Percent	Number	Percent
Female	5	45.5%	<5*	9.5%	7	21.9%
Male	6	54.5%	19	90.5%	25	78.1%
Unknown	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Total	11	100.0%	21	100.0%	32	100.0%
Race/Ethnicity	Number	Percent	Number	Percent	Number	Percent
White, non-Hispanic	<5*	36.4%	10	47.6%	14	43.8%
Black, non-Hispanic	6	54.5%	11	52.4%	17	53.1%
Am Indian/AK Native, non-Hispanic	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Asian/HI/Pacific Islander, non-Hispanic	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Hispanic	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Other, non-Hispanic	<5*	9.1%	<5*	<5.0%*	<5*	<5.0%*
Unknown	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Total	11	100.0%	21	100.0%	32	100.0%
Age at Diagnosis	Number	Percent	Number	Percent	Number	Percent
<13	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
13-14	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
15-24	<5*	18.2%	<5*	14.3%	5	15.6%
25-34	<5*	18.2%	8	38.1%	10	31.3%
35-44	<5*	36.4%	7	33.3%	11	34.4%
45-54	<5*	18.2%	<5*	<5.0%*	<5*	9.4%
55-64	<5*	9.1%	<5*	<5.0%*	<5*	6.3%
65+	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Unknown	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Total	11	100.0%	21	100.0%	32	100.0%
Exposure Category	Number	Percent	Number	Percent	Number	Percent
Male Sex w/ Male (MSM)	<5*	18.2%	9	42.9%	11	34.4%
Injection Drug Use (IDU)	<5*	18.2%	<5*	9.5%	<5*	12.5%

MSM & IDU	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
High-risk Heterosexual	<5*	36.4%	6	28.6%	10	31.3%
Transfusion/Hemophiliac	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
Perinatal Exposure	<5*	<5.0%*	<5*	<5.0%*	<5*	<5.0%*
No Identified/Reported Risk	<5*	27.3%	<5*	14.3%	6	18.8%
Total	11	100.0%	21	100.0%	32	100.0%

Note: Due to rounding, percentages may not add up to 100.

* Cell sizes less than 5 cannot be reported.

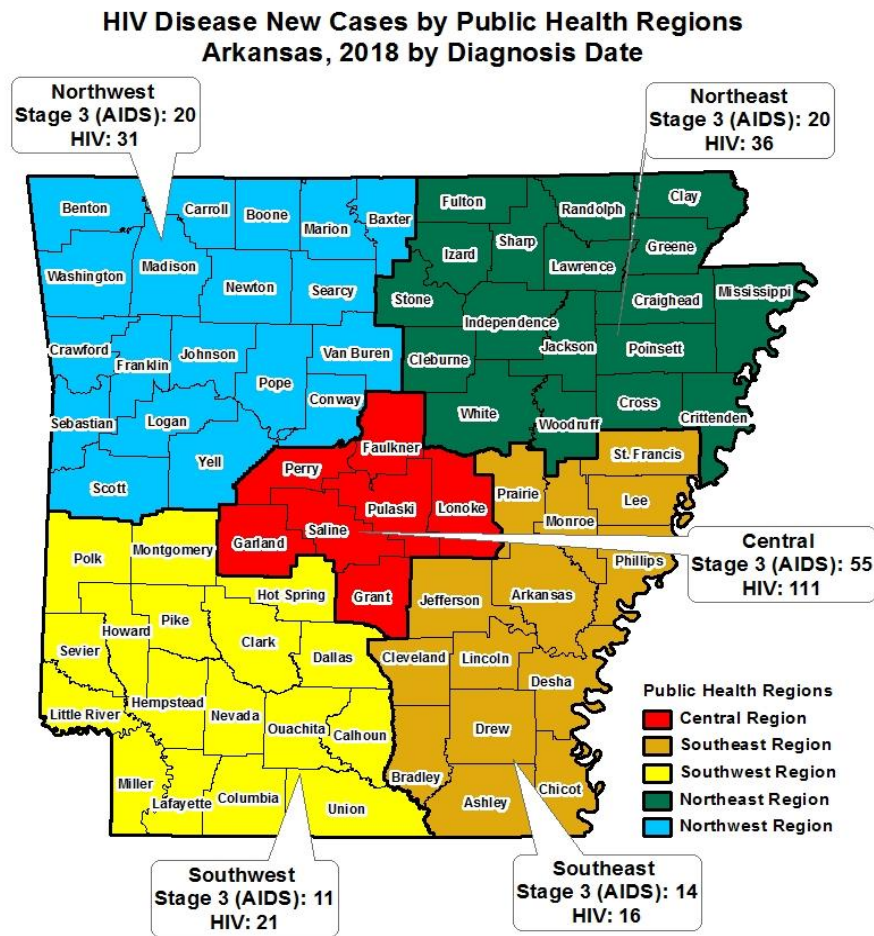
** Persons Living with Stage 3 (AIDS): the number of persons diagnosed as living with AIDS as of December 2018. This includes persons who were originally diagnosed as HIV (stages 0, 1 or 2) who progressed to AIDS sometime during the year.

*** Persons Living with HIV: the number of persons diagnosed as living with HIV (stages 0, 1 or 2) as of December 2018.

+ Persons Living with HIV Disease: the sum of the number of persons diagnosed as living with HIV (stages 0, 1 or 2) and those living with stage 3 (AIDS) as of December 2018.

Source: Arkansas eHARS (enhanced HIV/AIDS Reporting System), accessed July 26, 2019.

Figure 4. HIV Disease New Cases by Public Health Regions in Arkansas, 2018 Diagnosis Date



Date: August 13, 2019
 Source: Arkansas Department of Health
 Map created by: Marwa Sadawi

Data Source: Arkansas eHARS (enhanced HIV/AIDS Reporting System) accessed July 26, 2019

People Living with Diagnosed HIV in Arkansas: 2018

HIV Prevalence

As of December 31, 2018, there were 6,070 Arkansas residents living with HIV disease. A greater number of people are now living longer with HIV due to advances in medical treatment and care. From 2014 to 2018, the number of people living with diagnosed HIV in Arkansas increased by 10%. As of December 31, 2018, approximately 2,659 of the diagnosed HIV positive population had an AIDS-defining condition.

Sex

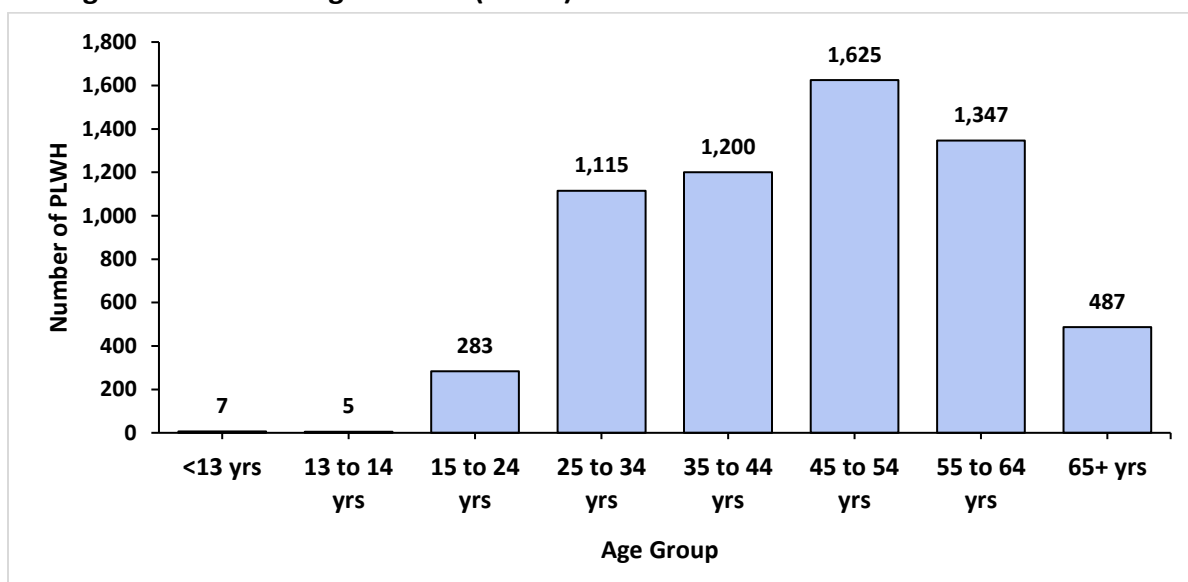
By the end of 2018, there were 4,721 males and 1,349 females in Arkansas who were living with an HIV diagnosis, with males representing 77.8% of the total HIV-positive population. Males were living

with HIV disease at a rate of 319.0 per 100,000, and females at a rate of 88.0 per 100,000. Males were 3.6 times more likely to be living with a diagnosis of HIV than females.

Current Age

Persons are living longer with HIV. By December 31, 2018, 84% of people living with HIV (PLWH) were between the ages of 25 to 64. The number of infections were highest among the 45 to 54 years (n=1,625), followed by the 35 to 45 years (n=1,200), and the 25 to 34 years (n=1,115) (Figure 13). The mean age for PLWH in Arkansas was 47 years old, at the end of 2018.

Figure 5. Age of Persons Living with HIV (PLWH) in Arkansas at the end of December 2018

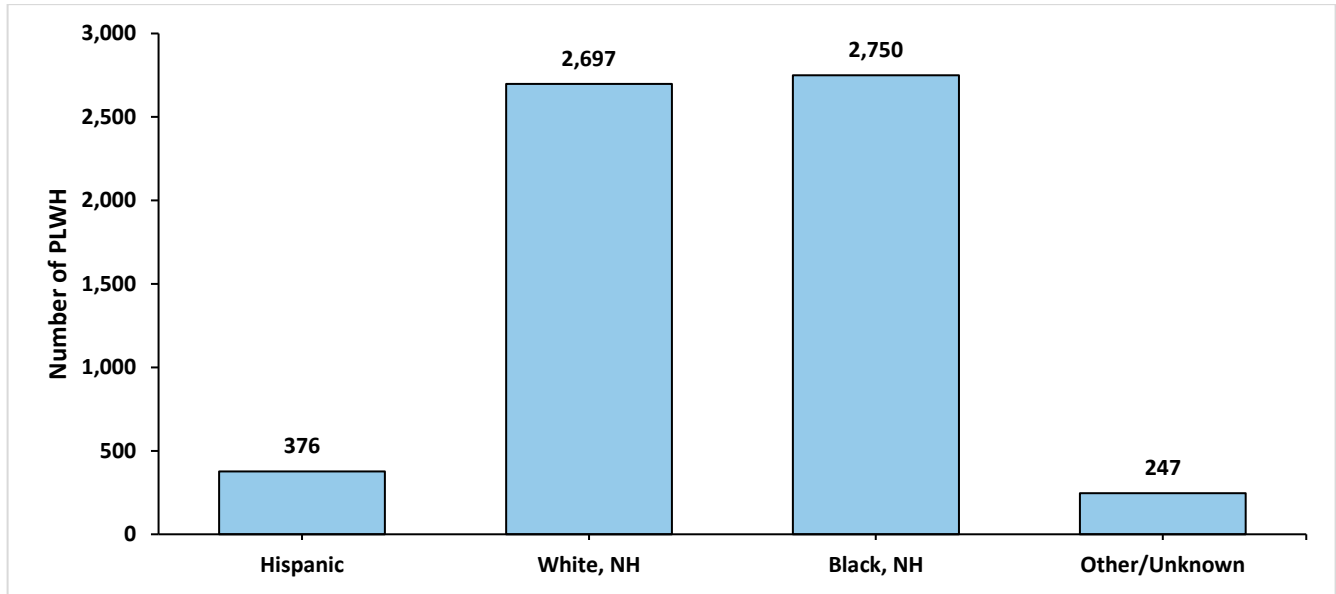


Race/ Ethnicity

In Arkansas, 2,750 (45.3%) people living with diagnosed HIV as of December 31, 2018 were non-Hispanic Blacks, followed by non-Hispanic Whites (2,697; 44.4%) and Hispanics (376; 6.2%) (Figure 14).

Non-Hispanic Blacks (571.7 per 100,000) were more than four times as likely to be living with HIV Disease compared to non-Hispanic Whites (121.9 per 100,000). Although non-Hispanic Blacks make up 15.7% of the population, they account for 45.3% of all PLWH.

Figure 6. Number of PLWH by race/ethnicity in Arkansas at the end of 2018

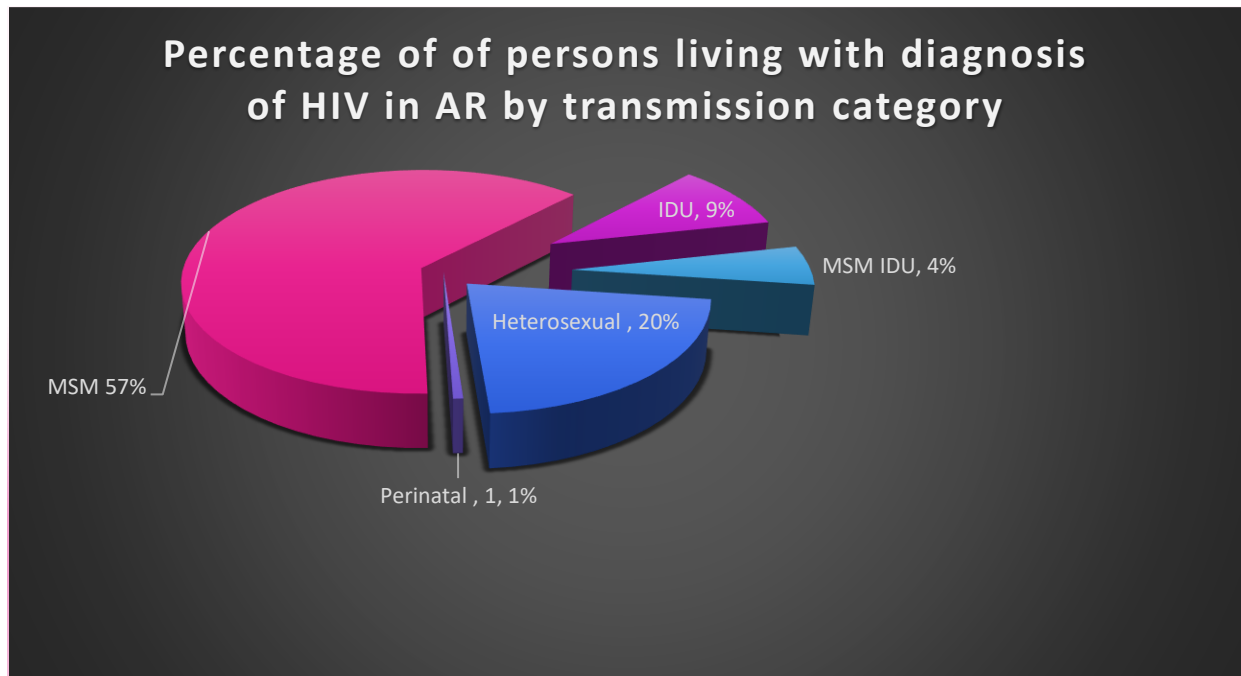


Transmission

At the end of 2018, 57% of all living persons with an HIV diagnosis were attributed to male-to-male sexual contact (MSM) (Figure 15). Heterosexual contact represented 20% of living cases, and 9% of cases were attributed to injection drug use (IDU). The breakout of MSM and IDU represented 4%. Approximately 9% of PLWH had no reported risk (NRR) or no identified risk (NIR) for transmission. Perinatal cases accounted for 1% of cases. Among women, heterosexual contact was the most common transmission risk (74%). Of all PLWH at the end of 2018, non-Hispanic Black MSM were the largest transmission risk group living with HIV (36.6%), followed by non-Hispanic White MSM living with HIV (25.58%). Non-Hispanic white females (3.9%) and Black females (7.2%) living with HIV attributed to heterosexual transmission (7.2%).

As it pertains to the “unknown” NRR and NIR transmissions, many persons often refuse to answer questions on the CDC adult confidential case report form for certain reasons of stigma still associated with HIV in Arkansas. However, sometimes with repeated visits and questioning by Disease Intervention Specialist (DIS) and Ryan White case managers, these gaps in data can be filled over time.

Figure 7. Percentage of Transmission Category of PLWH at the end of 2018



Treatment Resources for People Living with HIV

The state of Arkansas has limited financial resources and capacity for funding the cost of care (in terms of treatment, prevention and housing services) for persons living with HIV and AIDS in the state. Assistance from federal sources significantly augment state general revenue for providing these services.

Resources for HIV care encompass the continuum from housing, outpatient ambulatory health services (including medical visits, medication prescription for HIV, opportunistic infections, viral hepatitis and other select comorbidities; dental procedures, mental health consultations, laboratory testing), prescription and dispensing of pre-exposure prophylaxis (PrEP), to medical care coordination and nonmedical case management. Funding to ensure availability of these services are provided primarily through federal grant funding and state general revenue (including state Medicaid).

Care (Ryan White Part B, C, and D)

The State of Arkansas receives funding from the Health Resources and Services Administration for providing comprehensive HIV medical, dental, and behavioral health services to HIV positive persons in the state. The programmatic services for HIV care under the Ryan White Parts B, C, and D funding resources are available within the state.

Part B: The Arkansas Department of Health (ADH) administers the Ryan White Program Part B grant funds to ensure that all clients across the state with income up to 500% of the federal poverty level, uninsured or underinsured receive outpatient services from contracted physicians, dentists, and mental health specialists of their choosing wherever they reside in the state. To this end the ADH has a network of Agency-approved and contracted providers statewide.

	# of Contracts	# of Service sites
Physician	26	42
Dental	33	40
Hepatitis C	8	13
Mental Health	18	45

As of the time of this writing.

Part B Care coordination: Case management services for HIV clients are provided in all 75 counties. These counties are grouped into six (6) Ryan White Part B geographic Districts. There is a total of 15 service access sites, staffed by nonmedical and medical case managers for all Part B Program-approved and allowable activities. Arkansas Ryan White case management services are administered by **ARcare** (a federally qualified health center agency), under a multi-year subgrant agreement.

Laboratory: Two laboratory service companies, LabCorp and Quest Diagnostics, are contracted with the Part B Program for specimen analysis as ordered by Program-contracted physicians.

Parts C and D: Three Federally-qualified Health Centers receive direct HRSA funding to provide Ryan White Program Part C (for comprehensive primary health care in outpatient settings for people living with HIV disease) and Part D (for outpatient ambulatory family-centered primary and specialty medical care and support services for women, infants, children and youth living with HIV). These community-based agencies are also networked statewide and provide community-based services across multiple urban and rural health clinics.

1. ARcare
2. Jefferson Comprehensive Care System, Incorporated (JCCSI)
3. East Arkansas Family Health Center (EAFHC)

Linkage to Care Assistance

Linkage to Care Assistance: The Ryan White Program award provides funding under its MAI (minority AIDS Initiative-established in 1999 by Congress under all Ryan White Program Parts) to improve access to HIV care and health outcomes for disproportionately affected minority populations, including black populations. Through the Arkansas Infectious Disease Branch, MAI funds directly support outreach and education services for increasing minority access to needed HIV/AIDS medications through Part B AIDS Drug Assistance Programs (ADAP). MAI efforts are to ensure that healthcare inequities experienced by minorities living with HIV is addressed. Linkage to Care staff work with numerous partner and stakeholder entities across the state to reach clients lost to care; collaborate with disease intervention specialists to help newly-diagnosed clients get set up with HIV

case management and outpatient ambulatory services appointments and follow-up on the progress of these clients throughout the process.

Treatment (AIDS Drug Assistance Program)

Prescriptions (AIDS Drug Assistance Program): the ADH also administers the ADAP award to the state. The ADAP provides for HIV clients statewide who need assistance with their prescriptions, copays for provider visits and prescriptions, as well as health insurance premiums and cost share. The Program contracts with an in-state specialty pharmacy, **Health Care Pharmacy**, which dispenses and ships all medications to clients.

Housing (Housing Opportunities for Persons with HIV)

US Department of Housing and Urban Development (HUD) - Housing Opportunities for Persons with AIDS (HOPWA): Arkansas, in partnership with community non-profit organizations, called *project sponsors*, administer federal resources set aside to fund housing assistance programs for persons living with HIV. The U.S. Department of Housing and Urban Development (HUD) awards grant funding to the City of Little Rock (for services in Grant, Lonoke, Pulaski, Saline, Faulkner and Perry Counties), the Memphis Transitional Grant Area (TGA) under Shelby County, Tennessee (for services in Arkansas' Crittenden County) and the state of Arkansas (administered through the ADH Infectious Disease Branch for services across the other 68 counties in the state). HOPWA funds provide for direct housing and utility subsidy and complementary support services including housing case management. Core support for HOPWA includes:

- *Tenant-Based Rental Assistance (TBRA)*: rental assistance for units eligible under HUD's Fair Market Rent (FMR).
- *Short-Term Rent, Mortgage, & Utility (STRMU)*: assistance for rent, mortgage, or utilities for up to 21 weeks in any 52 week period.
- *Permanent Housing Placement (PHP)*: assists with assessment, one-time utility and or security deposits, and first month's rent.
- *Service Coordination/Support Services*: assistance with housing case management, education or job training support, etc.

The Northeast Arkansas regional AIDS, NARAN (also Arkansas supportive Services) provides direct services to eligible clients for the state under a multi-year subgrant agreement with the ADH.

Other Resources for HIV Care

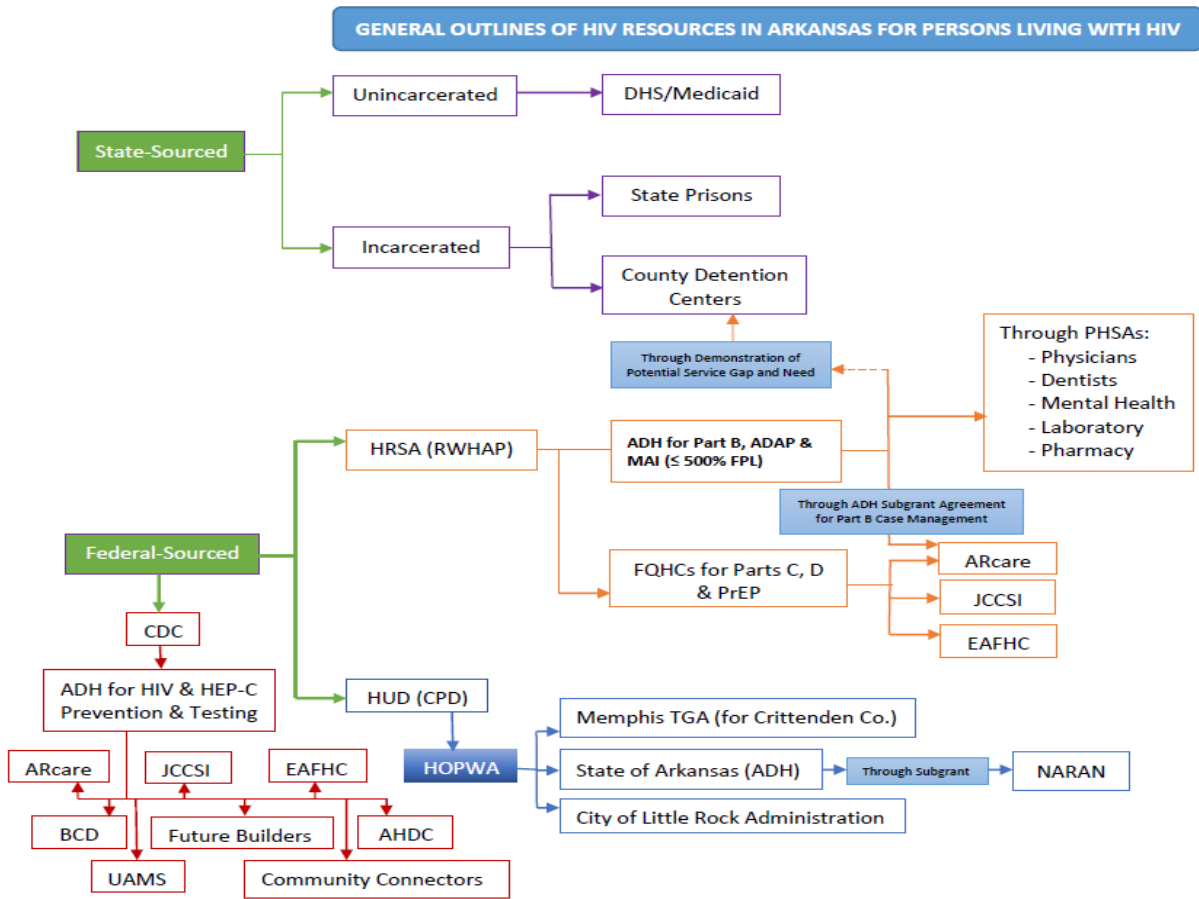
State of Arkansas general revenue provide resources for maintaining the overall HIV effort in the state by expanding access to any and all persons with HIV who may not be provided for by those services covered under federal assistance, or who are otherwise rendered ineligible for federally-funded services due to grant guidelines (example: payer of last resort, incarcerated, etc.). The Medicaid, through the state Department of Human Services (DHS) fund HIV services for women, infants and children not in the corrections system. The state Department of Corrections (ADC/DOC) administers state correctional facilities and provides for the care and treatment of all institutionalized

persons. Local county administrations through their sheriff departments or office of the county judge provide resources for the care of the short-term incarcerated. In the event where local sheriff departments are resourced-challenged there is an avenue in place whereby they may collaborate with the state’s Ryan White Part B Program to ensure continuity of medication access for jailed clients. Documentation justifying such needs must be provided by the jail or sheriff department. See the general outlines of HIV resources for persons living with HIV in Arkansas below.

Testing

Though these resources are available in the state for PLWH, there are also resources for HIV testing, education, and prevention. Supported through funding from the Center for Disease Control and Prevention (CDC), the ADH Infectious Disease Branch works directly with multiple community-based organization (CBO) partners. These partner CBOs, through contractual agreements, ensure statewide availability of and access to prevention and testing resources including condoms, testing kits and voluntary counseling and testing (VCT) training.

Figure 7. General Outlines of HIV Resources in Arkansas for Persons Living with HIV



People Living with Diagnosed HIV and other Co-Infections:2018

Sexually Transmitted Infections (Chlamydia, Gonorrhea, Syphilis)

Sexually transmitted infections (STIs) are indicators of ongoing high-risk sexual behavior, such as multiple partners and inconsistent condom use. Having a concurrent STI can increase the likelihood that someone with HIV might transmit HIV to uninfected partners because having a sore, break in the skin, or inflammation from a STI may allow an HIV infection that would have been stopped by intact skin.

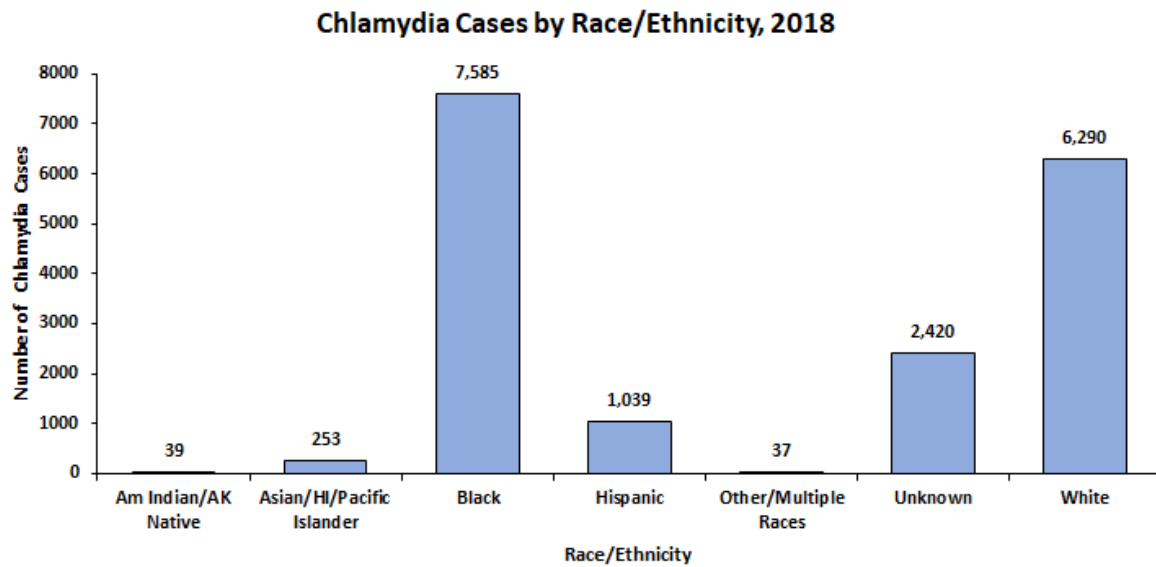
Arkansas is a medium morbidity state for sexually transmitted infections including HIV, gonorrhea, chlamydia, and syphilis. Compared to the rest of the United States, Arkansas ranked 11th for chlamydia, 8th for gonorrhea, and 18th for syphilis. In 2018, there were 17,663 cases of chlamydia and 7,300 cases of gonorrhea reported in Arkansas. The rates for chlamydia and gonorrhea in Arkansas have been higher than the national rate every year from 2015-2018. During 2015-2018 in Arkansas, the rate of chlamydia increased 11.6% and 54.4% for gonorrhea. In 2018, there were 288 cases of primary and secondary syphilis (P&S), 364 cases of early non-P&S, and 25 cases of congenital syphilis reported. The rates for each increased, 138.3% P&S syphilis; 71.9% non-P&S syphilis; and 418.3% congenital syphilis. During this time, congenital syphilis was the greatest increase of any notifiable STI in Arkansas.

Persons diagnosed with STIs are more susceptible to HIV, and early identification of persons through their diagnosis and treatment of STIs is an indicator for ensuring prevention education and linkage to PrEP care. In addition, PLWH who have repeat diagnosis and treatment of STIs receive continue education regarding prevention, and access to services that provides support for ensuring their continued compliance in HIV care and adherence to medications. In 2018, there were 12 PLWH diagnosed with chlamydia, 18 PLWH diagnosed with gonorrhea, and 42 PLWH diagnosed with syphilis.

Chlamydia

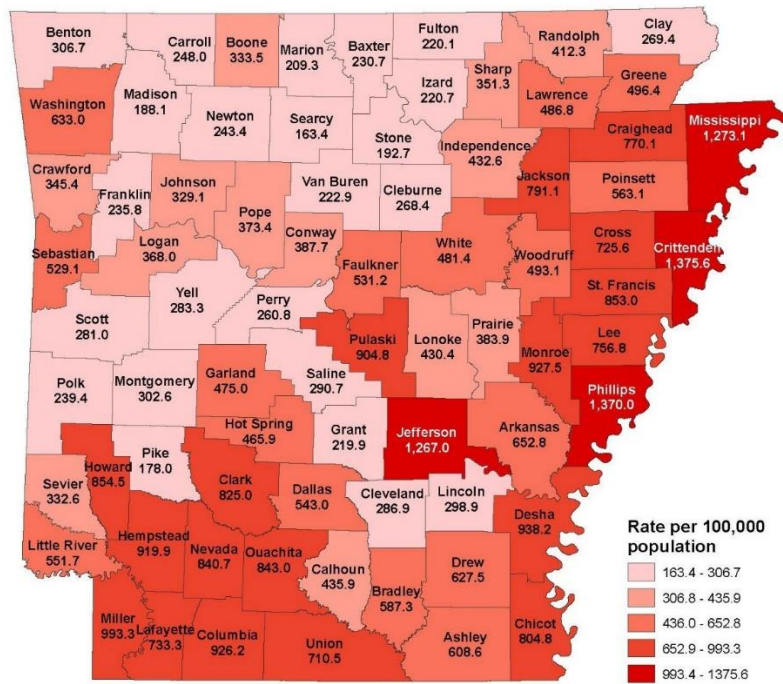
The majority of chlamydia cases (70.8%) were diagnosed among females, and most commonly diagnosed in the ages of 20-24 years (38.2%), 15-19 years (30.8%), and 25-29 year (16.5%). Non-Hispanic Blacks accounted for the most chlamydia diagnoses (7,585; 42.9%) in 2018.

Figure 8. Chlamydia Cases by Race/Ethnicity 2018



The rate of chlamydia infections in 2018 was 586.0 per 100,000 persons. Counties in the Delta region and along the Louisiana border had the highest rates with Crittenden County having the highest rate (1,375.6) in the state (Figure 18).

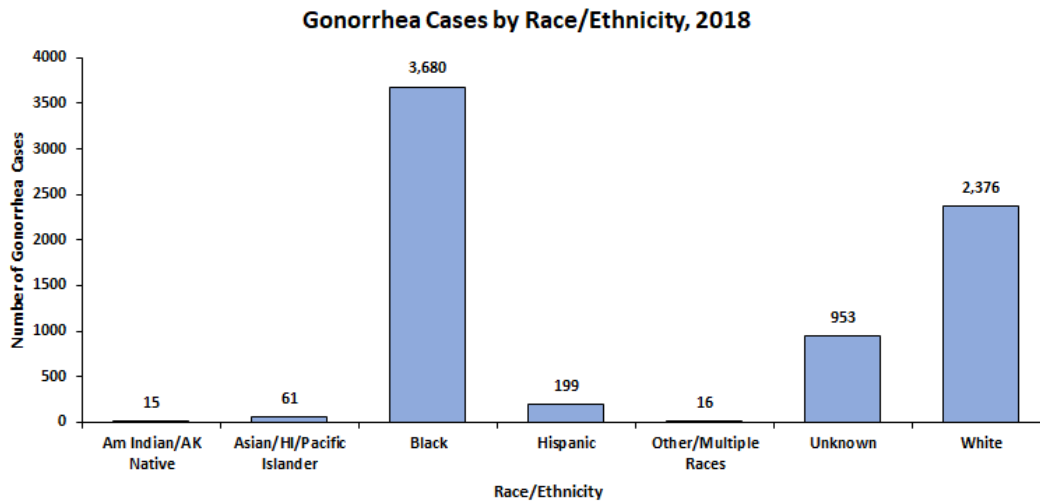
Figure 9. Chlamydia- Rates of Reported Cases per 100,000 Persons by County, Arkansas 2018



Gonorrhea

The rates of infection for gonorrhea were similar among males (237.2 per 100,000) and females (247.0 per 100,000). Half of all gonorrhea infections (50.4%) were diagnosed in the Black population, and most commonly diagnosed among people ages 20-24 years (31.8%), followed by 15-19 years (21.6%) and 25-29 years (20.2%).

Figure 10. Gonorrhea Cases by Race/Ethnicity 2018



In 2018, the rate of reported gonorrhea infections in Arkansas was 242.2 per 100,000. Like Chlamydia, Crittenden County had the highest rate (655.7 per 100,000). In addition, counties located along the Delta and Southwestern regions had high rates as well.

Syphilis

Primary and Secondary (P&S) syphilis was diagnosed most frequently in 2018 in the ages of 25-29 years (25.3%) and 20-24 years (24.7%). Males accounted for 3 times the number of P&S syphilis cases compared to females; and Blacks had the highest rate of infection (29.3 per 100,000). Early non-P&S syphilis had the highest rates within the ages of 25-29: males represented 67.6% of all cases and females represented 32.4%. Black individuals had a higher rate at 38.9% of infection compared to Hispanics at 6.9% and Whites at 6.6%.

Treatment

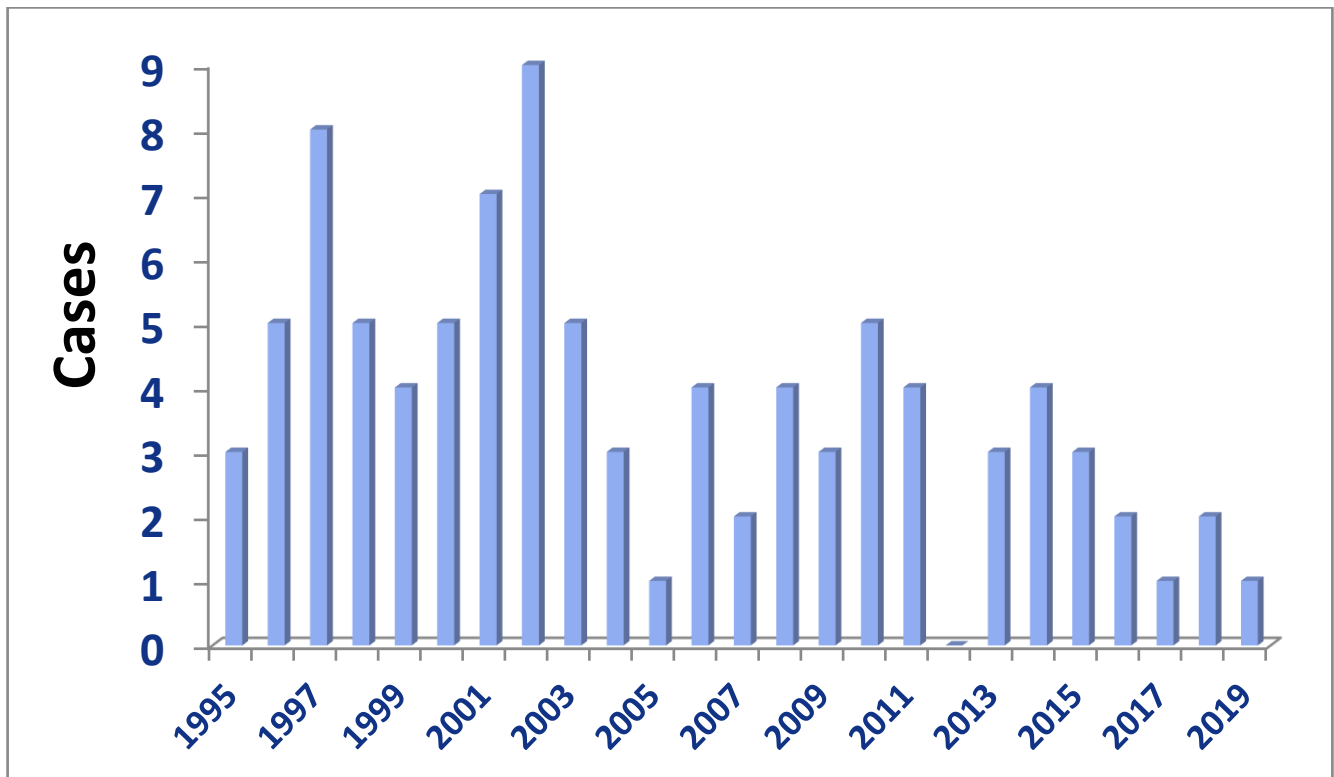
Testing and treatment of STIs is an effective tool in preventing the spread of HIV. Untreated STIs are a common cause of pelvic inflammatory disease, infertility and chronic pelvic pain. In addition, they can increase the spread of HIV and cause cancer. Pregnant women and newborns are particularly vulnerable. STI treatment reduces an individual's ability to transmit HIV. In Arkansas, persons insured and uninsured can be tested and treated for chlamydia, gonorrhea, and syphilis at local health units

within each county. Medical providers throughout the state can also test and treat persons, and ensure to report cases and medication treatments to the Arkansas Department of Health.

Tuberculosis (TB)

In 2018, there were 79 cases of TB in Arkansas. The reported cases identified two (2) persons co-infected with HIV. These cases were known HIV positive cases prior to being diagnosed with TB. Through program collaborations and service integration (PICS), between TB and HIV Programs within the ADH Infectious Disease Branch, the incidence of TB-HIV in Arkansas been reduced significantly. Unfortunately, it is not yet zero. There does continue to be missed opportunities for screening, given that all TB and latent tuberculosis infection (LTBI) cases should be screened for HIV and all HIV cases should be screened for TB. Also, some providers simply don't follow the guidance that all HIV cases in their clinics should have an annual TB screening; with the exception of the Ryan White Part B network providers in which the program requires as part of cares services for annual TB screenings of patients.

Figure 11. TB Cases Among People Living with HIV in Arkansas, 1995-2019



Hepatitis C

In 2019, the ADH Infectious Disease Branch hepatitis C program investigated all laboratory reports of hepatitis C to determine if cases were chronic or acute. Evaluation and analysis of the data collected from these investigations illustrated that 25.6% of persons, aged 50-59 diagnosed with chronic hepatitis C and 23.0% of persons aged 30-34 diagnosed with acute hepatitis C. Between genders,

males had the highest percentage for diagnosis of chronic and acute. The most recent data analysis of HIV- HCV co-infection illustrated that in 2019 the state of Arkansas had 46 persons (2.2%) of “chronic” hepatitis C cases with a reported diagnosis of HIV.

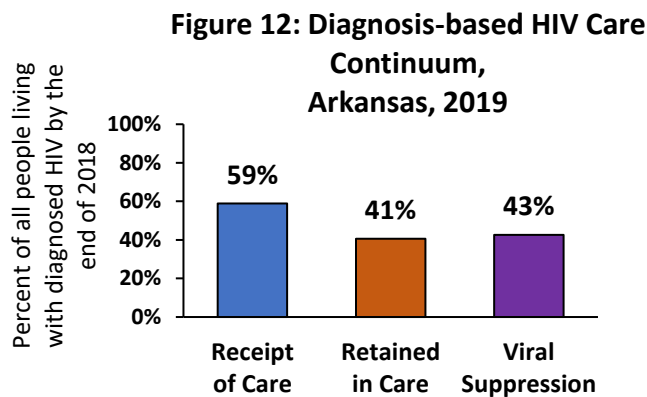
In 2020, the Center for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) began recommending that all people with HIV be vaccinated against hepatitis A (HAV), unvaccinated people with HIV receive hepatitis B (HBV) vaccination, and one-time hepatitis C (HCV) testing of all adults including those with HIV. The ADH Infectious Disease Branch oversees public health services for education, testing, linkage to care, and surveillance of HCV. Due to the effect that HCV infection can cause on the management of HIV, the Infectious Diseases Society of America (IDSA) recommends that people who are co-infected with HIV and HCV be provided with curative, direct-acting antiviral medications to treat their HCV infection. Through the Arkansas Ryan White Part B and AIDS Drug Assistance Program (ADAP), laboratory services include a hepatitis A, B, and C panel; hepatitis A and B vaccination; and curative medication treatments for HCV. Since 2015, the program has provided hepatitis C care and treatment to 49 HIV co-infected persons within the state.

HIV Continuum of Care

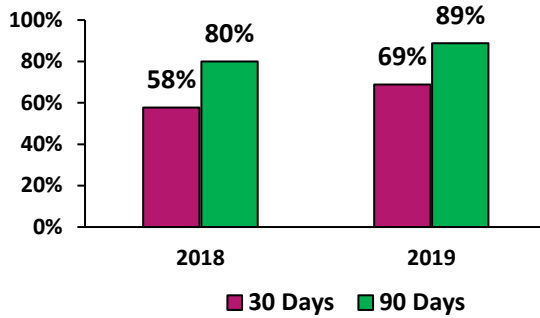
The HIV care continuum begins with a diagnosis of HIV infection. The only way to know for sure that people are infected with the HIV virus is to ensure increase access to testing. People who are unaware of their status do not know if they potentially have a virus that can be transmitted to others, and if they need to access care and treatment for staying healthy. Screening persons for HIV is also an opportunity for linking persons testing HIV negative to a health care provider for pre-exposure prophylaxis (PrEP).

The state of Arkansas has an HIV care infrastructure for HIV education, testing, and care services; however, resources are limited especially in rural areas of the state. The ADH, community based organizations, community stakeholders, and federally qualified health centers (FQHCs) for many years have worked to advocate for expansion of workforce and resources statewide; and for the implementation of innovative activities for HIV elimination. The Arkansas HIV Continuum of Care, Figure 19 and Figure 20, describes the number of people who are at each step of the continuum as a percentage of the number of people diagnosed with HIV before the end of 2018 and living in Arkansas at the end of 2019 (n=6,376).

- **Receipt of care** is measured as the percentage of persons with diagnosed HIV who had at least one CD4 or viral load test in 2019 (n=3,756).
- **Retained in care** is measured as the percentage of persons with diagnosed HIV who had two or more CD4 or viral load tests, performed at least three months apart (n=2,589).
- **Viral suppression** is measured as a viral load test result of ≤ 200 copies/mL at the most recent viral load test (n=2,717).
- **Linked to care** measures the percentage of people receiving a diagnosis of HIV in a single year who had one or more documented CD4 or viral load tests within 30 days and 90 days of diagnosis. Because this measure is limited to people with HIV diagnosed in a single year, it cannot be directly compared to other steps in the continuum.



**Figure 13: Linked to Care, Arkansas,
2018-2019**



Analysis of the HIV Continuum of Care illustrated the following:

- 59% of people living with HIV (PLWH) in Arkansas received care in 2019.
- 41% of PLWH in Arkansas had at least two (2) medical visits or labs at least 3 months apart in 2019.
- 43% of PLWH in Arkansas achieved viral suppression (≤ 200 copies/mL) on their most recent viral load test in 2019.
- Of the 279 people with new HIV diagnoses in Arkansas in 2018, 58% (n=161) were linked to care within 30 days of diagnosis and 80% (n=223) were linked within 90 days of diagnosis.
- Of the 276 people with new HIV diagnoses in Arkansas in 2019, 69% (n=190) were linked to care within 30 days of diagnosis and 89% (n=245) were linked within 90 days of diagnosis.

Glossary of Terms and Acronyms

ADAP	AIDS Drug Assistance Program
ADH	Arkansas Department of Health
Stage 3 (AIDS)	Acquired Immune Deficiency Syndrome
CDC	Center for Disease Control and Prevention
DIS	Disease Intervention Specialist
eHARS	Enhanced HIV/AIDS Reporting System
HIV	Human Immunodeficiency Virus (Stages 0, 1, and 2)
IDU	Intravenous (Injection) Drug Use; illegal drugs administered into the body with needle
Incidence	Number of new cases of a disease divided by the population at that specific time
MSM/IDU	Men who have sex with men and engage in Intravenous (Injection) Drug Use
NIR	No Identified Risk
NRR	No Risk Reported
PLWH	Persons Living With HIV
PLWHA	Persons Living With HIV Disease
Prevalence	Number of living cases of HIV or Stage 3 (AIDS) divided by the population at that specific time
Rate	The proportion of people with a disease in a specific population, over a specific time period

Risk Factor	An aspect of personal behavior and environmental exposure, or an inborn or inherited characteristic that is associated with an increased occurrence of disease
STD	Sexually Transmitted Disease
Surveillance	The ongoing, systematic observation of a population for rapid and accurate detection of the occurrence of diseases
TGA	Transitional Grant Area
Unmet Need	The need for HIV-related health services by individuals with HIV who are aware of their status, but are not receiving regular primary health care

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