Peer-to-Peer Health Promotion and Pop-up Clinics: Community-Based Strategies for HIV Reduction among Transgender Survival Sex Workers in Louisiana

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Executive Summary

Audience

The Louisiana Department of Health (LDH), which has established programs related to sexual health, reproductive health, and gender-affirming care for high-risk, low-income populations.

Problem

HIV disproportionately impacts Black and Latinx transgender survival sex workers (TSWs) in Louisiana due to stigma, inadequate healthcare access, and high-risk sexual behaviors, compounded by legislative and social inequalities.

Objective

To recommend policy interventions that decrease HIV prevalence among Louisiana's TSWs by addressing barriers to healthcare access, social stigma, and the lack of targeted support services.

Current Policies and Protocol

The current state policies inadequately address the specific needs of TSWs, lacking in comprehensive sexual health services and support systems. An analysis of existing protocols shows gaps in inclusivity and accessibility, namely:

- Cultural and systemic stigma leads to exclusion from many health and social services.
- Economic insecurity compels TSWs into survival sex work, increasing exposure to HIV.
- TSWs have limited access to gender-affirming healthcare and HIV preventive services.

Policy Recommendations

- **Pop-up clinics:** Establish pop-up clinics in existing community spaces that function as safe spaces for HIV testing and peer-to-peer health promotion tailored to TSWs.
- **Peer-to-peer health promotion:** Initiate community-led health promotion programs that involve TSWs in the design and dissemination of HIV preventive education.

Policy Implementation

- Implementation will begin by engaging TSW community leaders to set up pilot pop-up clinics in high risk areas. Clinics will focus on peer-to-peer health promotion and improved sexual healthcare services.
- Quarterly evaluations will measure engagement levels, service uptake, and health outcomes, including HIV prevalence rates, patient retention, and changes in risky sexual behaviors.
- Primary interim goals are the reduction of HIV transmission by 20% and improvement in sexual health literacy by 30% over the first two years, consistent with the objectives of the LDH's 2022-2026 Louisiana HIV Prevention and Care Plan.

Conclusion

Addressing Louisiana's elevated HIV rates among TSWs demands a multifaceted approach that integrates community engagement, healthcare reform, and legislative action. The proposed policies ultimately aim to reduce HIV prevalence through fostering community.

Introduction

Louisiana is a critical epicenter of the HIV epidemic

The HIV epidemic in the United States continues to pose a significant public health challenge. According to the U.S. Department of Health and Human Services (2023), as of 2023, approximately 1.2 million people in the United States are living with HIV. That year, there were nearly 37,000 new HIV diagnoses across the country (U.S. Department of Health & Human Services, 2023). Marginalized communities are disproportionately affected by the epidemic: Black and Latinx people are overrepresented in the national HIV burden, regardless of gender (Bowleg et al., 2022). In 2022, Louisiana had one of the highest rates of new HIV diagnoses in the country, with 23.3 new cases per 100,000 people, significantly surpassing the national average of 11.5 (Louisiana Department of Health, 2022a). Urban areas such as Baton Rouge and New Orleans are particularly affected, ranking seventh and ninth respectively for new HIV diagnoses per capita, among all major U.S. cities (Louisiana Department of Health, 2022b). Altogether, around 22,500 people in Louisiana are diagnosed with HIV, as of 2022 (Louisiana Department of Health, 2022b).

Pathology of HIV

Human Immunodeficiency Virus (HIV) targets the immune system, primarily affecting CD4 cells that are essential for immune response coordination (Govindaraj et al., 2023). By integrating its RNA into the DNA of these cells, HIV transforms them into viral replicators, consequently reducing the body's defensive capabilities against infections and diseases (Govindaraj et al., 2023). Continuous administration of pre-exposure prophylaxis (PrEP) or antiretroviral therapy (ART) has been shown to preserve immune function and drastically reduce viral transmission (Masenga et al., 2023). Despite the effectiveness of these treatments as

prevention methods, uptake among high-risk groups is hindered by pervasive stigma, limited healthcare accessibility, and a lack of targeted outreach and education efforts (Clement et al., 2024). In Louisiana, the HIV epidemic is notably pronounced among high-risk groups, including Black and Latinx TSWs, who face substantial barriers to accessing PrEP and ART (Clement et al., 2024). HIV remains a significant public health concern due to its capacity to debilitate the immune system, leading to potentially fatal opportunistic infections and cancers if left untreated (Govindaraj et al., 2023).

HIV as a social determinant of health

HIV prevalence among Black transgender women can range from 44% and 62% and between 26% and 35% for Latinx transgender women, who make up the majority of TSWs in Louisiana (Sevelius et al., 2016). Prevalence within these communities is substantially higher compared to HIV prevalence among white transgender women. Inadequate healthcare access for these populations, which hinder their engagement with HIV diagnosis, treatment, and management services, results in lower rates of treatment adherence and viral suppression, perpetuating transmission and poor health outcomes (Reisner et al., 2016; Santos et al., 2021). The economic burden of lifetime treatment and associated productivity losses often further stress people living with HIV (Santos et al., 2021).

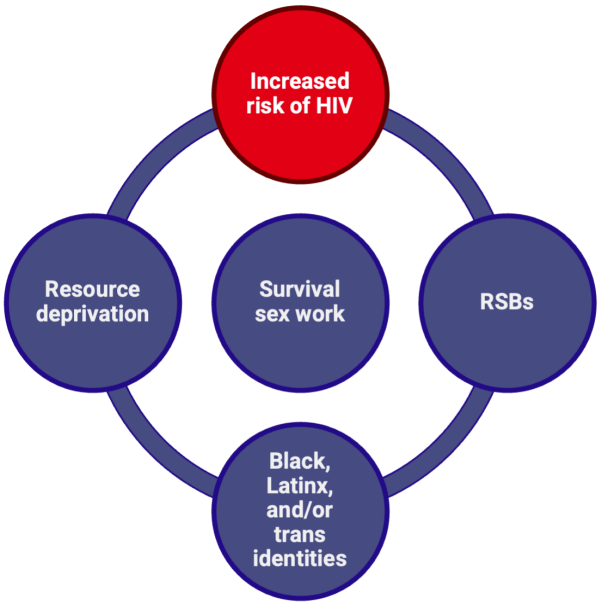
Risky sexual behaviors (RSBs), including sex work (SW), increase risk of HIV

Risky sexual behaviors (RSBs) include a high number of sex partners (especially casual partners), lack of barrier methods (including failure to negotiate condom usage), less frequent STI testing of self or partners, alcohol consumption or drug usage before or during sex, partners who are HIV-positive and not in remission, and transactional sex (Keizur et al., 2020). RSBs are more common among people of color, with Black and Latinx people constituting the majority

across all genders, including transgender people (Lett et al., 2022). Lett et al. found that an average of 32.4% and 33.3% of Black and Latinx transgender people, respectively, have engaged in transactional sex, compared to 4.3% to 14.6% of transgender people of other ethno-racial identities (2022).

Transgender people are more likely to engage in survival SW

Survival SW is a form of transactional sex, performed out of extreme need; survival sex workers trade sexual acts for food and shelter, for other basic amenities, or for drugs (McTighe & Haywood, 2017). Sex work, incarceration, substance use, homelessness, and poverty are all correlated with one another, stemming from family rejection and the general lack of support networks (Dewey & St. Germain, 2015; Sevelius, 2013). Thus, limited access to social, economic, and healthcare resources contribute to high HIV prevalence. Being especially economically and socially marginalized across races, transgender people are more likely than cisgender people to participate in survival SW, especially if they are Black or Latinx (Lett et al., 2022). Lett et al. (2022) argue that transactional sex, especially survival sex work, is one way that transgender people "embody" discrimination, especially in the form of resource deprivation.



SW is highly correlated with the rate of HIV transmission, especially within transgender communities, where on average 21% of women, 1.2% of men, and 16.1% of the overall population are HIV positive (Lett et al., 2022). Lett et al. (2022) found significant associations

between prevalence of RSBs, especially drug usage and transactional sex, and experiences of interpersonal transphobia. Thus, structural racism and transphobia, which are highly correlated with RSB prevalence, are significant social determinants of HIV for TSWs (Bowleg et al., 2022; Sevelius, 2013). The intersectionality of legal and societal stigma, race, and economic status subject Black and Latinx TSWs, the majority of TSWs in Louisiana, to higher rates of HIV, underscoring the need for tailored policy interventions. (Crenshaw, 1997).

Audience

This policy recommendation is addressed to the Louisiana Department of Health (LDH), which plays a pivotal role in addressing the HIV epidemic in Louisiana. Through the Get Loud Louisiana initiative, the LDH has expanded access to antiretroviral therapy and testing services for HIV and other sexually transmitted infections (STIs) among high-risk and low-income groups through operating 80 STI clinics that accept Medicaid and collaborating with community organizations (Louisiana Department of Health, 2023, 2024). Through the Title X Public Health Service Act, the LDH also administers multiple health programs which intersect with the unique sexual health needs of trans people, especially TSWs, such as those for family planning, reproductive health, sexual education, and care coordination (Louisiana Department of Health, 2022a, 2022b). The LDH has implemented pilot programs for transgender healthcare, including hormone replacement therapy and mental health support, by partnering with community organizations like CrescentCare and Louisiana Trans Advocates (Louisiana Department of Health, 2023). However, the establishment of a state-funded program dedicated to transgender healthcare remains unexplored (Louisiana Department of Health, 2024). This presents an opportunity for the LDH to pioneer a state-funded program specifically dedicated to transgender healthcare. By focusing on the unique needs of the transgender community, such a program

could not only enhance sexual healthcare tailored to this group but also pave the way for broader advancements in transgender medicine in the future.

Historical and Current Political Context

Sexual conservatism in Louisiana

Sexual conservatism in Louisiana is deeply rooted in Evangelical Christian and Catholic traditions, which emphasize traditional family values and the concept of sexual purity (Lambda Legal & Movement Advancement Project, 2019). This religious framework often guides public discourse around sexual ethics by heavily emphasizing the importance of marriage and family and advocating for the protection of children from perceived moral threats (Lambda Legal & Movement Advancement Project, 2019). Sexual conservatism thus influences local policies and community attitudes toward sexual education, abortion rights, and LGBTQ+ rights in Louisiana. Indeed, sexual education is not required of any school curriculum in Louisiana and can only be taught in grades 7-12, with an emphasis on abstinence over other forms of contraception (Louisiana Public Health Institute, n.d.; Movement Advancement Project, 2022). The state prohibits the inclusion of material that depicts homosexual activities and does not require instruction on consent (Movement Advancement Project, 2022; Sexuality Information and Education Council of the United States (SIECUS), 2024). Likewise, with the overturning of *Roe v. Wade* in June 2022, an anticipatory "trigger ban" went into effect, which bans all abortions after six weeks, with no exceptions for rape and/or incest (Center for Reproductive Rights, n.d.). Exceptions are only made for cases with substantial risk of death or impairment to the patient in continuing the pregnancy and in the case of "medically futile" pregnancies, though a medical provider's assessment of risk must be accepted in court before the abortion is permitted (Center for Reproductive Rights, n.d.). Louisiana law requires mandatory 72-hour waiting periods;

extensive, biased counseling; and an ultrasound; as well as stringent architectural standards for abortion clinics akin to those for surgical centers, which collectively aim to deter abortion procedures (Center for Reproductive Rights, n.d.). Conservative sexual values in Louisiana also impact the rights of LGBTQ+ and transgender people, manifesting in policies that restrict their freedoms compared to other states. State laws do not comprehensively protect against discrimination based on sexual orientation or gender identity, affecting access to healthcare and employment (Lambda Legal & Movement Advancement Project, 2019). These policies reflect a broader societal project for limiting discussions around sex, sexuality, and health to conform with conservative sexual ethics.

Institutionalization of social stigma against sex workers, especially TSWs

The racial and economic marginalization of TSWs in Louisiana is compounded by the state's "criminalization crisis" of sex work, most notably through the "Crime Against Nature by Solicitation" (CANS) statute, which elevated the misdemeanor charge of prostitution to a felony charge and mandated registration as a sex offender (McTighe & Haywood, 2017). McTighe & Haywood (2017) contend that there is a "racialized genealogy" to the pattern of convictions under the statute: four out of every five people convicted under the statute are Black (265). Thus, CANS has become a method of publicly identifying, quarantining, and contact tracing predominantly Black and trans sex workers, whose profession is seen as morally deviant (McTighe & Haywood, 2017).

Though CANS and prostitution are still criminal charges, consequences of being convicted under the CANS statute have lessened. Penalties for CANS convictions are now equalized to those for prostitution (Center for Constitutional Rights, 2023). From 2012, new convicts under the CANS statute are not required to register as sex offenders (Center for

Constitutional Rights, 2023). In 2013, a class action lawsuit led to the removal of all sex workers convicted prior to 2012 under the CANS statute from the sex offender list (Center for Constitutional Rights, 2023). TSWs in Louisiana, especially Black and Latinx TSWs, continue to be disproportionately affected by these charges, in addition to the state's recent restrictions to reproductive and gender-affirming healthcare, and bills which seek to define transgender people by sex assigned at birth and ban discussions and educational material about sexual orientation or gender identity (Louisiana Trans Advocates, 2023, 2024).

Lack of trans-inclusive community spaces

It follows that transgender bodies and sexuality are not discussed, due to institutionalized stigma However, this does not mean that TSWs are wholly uninformed about HIV and RSBs; before information dissemination through the Internet, street knowledge shared through friendship and communal support from other TSWs proved crucial to initiating trends of sexual risk reduction (Abdul-Quader et al., 1990). This suggests that TSWs can possess situated knowledge of HIV and RSBs, but that support networks are crucial for information dissemination. TSWs without access to social networks—often younger, more impoverished, and more vulnerable to RSBs—are also those with the least access to this information and encouragement to participate in harm reduction (Dewey & St. Germain, 2015; Nappa et al., 2022). Trans-inclusive community spaces, which would allow for such discussions, are currently few in number.

Gaps in sexual healthcare

Indeed, spatial analysis revealed that Louisiana had no LGBTQ+ community health centers, which could be able to provide consolidated sexual health and general health services to sexual and/or gender minority patients (Goldhammer et al., 2023). Consolidation improves

patient access and trust in providers, leading to better patient retainment (Goldhammer et al., 2023). This lack of LGBTQ+ centers, institutions which actively show inclusivity, can foster feelings of invalidation and discomfort in patients who visit alternative institutions, which are often highly patriotic, religious, or gendered in the American South (Clary et al., 2023; Martos et al., 2017). HIV rates are further exacerbated by barriers to healthcare access on the basis of race, especially the deliberate exclusion of majority Black, Latinx, and low-income housing areas of urban Louisiana from public sexual health initiatives, such as condom distribution (McTighe & Haywood, 2017).

Current Interventional Context

Interventions to address the above issues can be broadly categorized as either (1) delivery of HIV-related healthcare, or (2) improvement of social support networks for individuals. It should be noted that these interventions do not specifically target TSW populations.

Initiatives expanding HIV care delivery

Specialized health and support services, such as discreet and point-of-care HIV testing and treatment in low-income and high-risk communities, have been shown to increase patient retention and use of services (Clary et al., 2023; Keizur et al., 2020; Sevelius, 2013). Integrating healthcare into community spaces also successfully increased rates of HIV and STI testing and treatment. A pilot program offering testing and treatment at hair salons, where hair stylists doubled as "lay health workers," provided a safe space where patients could "drop-in" for sexual healthcare and consultations (Palmer et al., 2022).

Peer-to-peer community health initiatives

Peer-to-peer health promotion at queer-friendly sites of recreation, such as clubs and bars, showed moderate success (Bassett et al., 2019; Palmer et al., 2022). Peer leaders with established

trust within local queer communities engaged patrons in discussions about RSBs, encouraging safer sex practices, negotiation skills for condom usage, and STI testing (Arayasirikul et al., 2017; Bowleg et al., 2022; Lett et al., 2022; Martos et al., 2017; Sevelius, 2013). These interactions were random, in contrast to specialized recreational spaces with a self-selected clientele interested in peer-to-peer manualized care and support; the latter showed better rates of participation and retention (Goldhammer et al., 2023). Independent of their success in driving down rates of RSBs and HIV, community-based approaches built trust by showing a "rare understanding of the institutions that mattered to the people they served," and were able to engage otherwise difficult-to-reach individuals or groups of people (McTighe & Haywood, 2017).

Gaps in policy

There are two primary gaps in existing policy interventions. (1) First, interventions do not specifically target transgender people or sex workers, though they could be adapted to meet the unique needs of TSW populations through the implementation of transgender healthcare, harm reduction practices, and support networks for TSWs. The existing programs, while well-intentioned, lack specificity and often do not reach those most at risk, such as transgender women of color, who continue to experience the highest rates of HIV. (2) Second, interventions lack community-building capacity due to the lack of such places for specifically transgender communities. While queer or sexual-minority communities have spaces for in-group congregation, gender-minority communities do not have transgender-specific places of gathering. Moreover, utilization of spaces of recreation, indulgence, or escapism by external entities (such as the LDH) risks pushback, rather than participation, from TSW and transgender communities. The public nature of these establishments would make participants vulnerable to policing, as

evidenced by decades of police surveillance of queer establishments, including the famous Stonewall Riots and Compton Cafeteria Riot. Thus, an effective solution must combine healthcare delivery with community building, such as through peer-to-peer health promotion in trans-focused LGBTQ+ community health centers (Goldhammer et al., 2023). Martos et al. suggest determining locations based on need: based on the HIV disease landscape in Louisiana, centers should be established in urban areas first and later redirect attention toward rural communities (2017).

TSWs, who are already at elevated risk of contracting HIV due to RSBs related to survival SW, are at higher risk of contracting HIV if they are Black and Latinx, low-income, or live in the American South. TSW communities in Louisiana, exist at the intersection of these risk factors, but are not receiving the specialized care they need. Pilot programs have demonstrated the potential for trans-focused community health centers, which present a less intimidating entry to sexual healthcare and RSB reduction methods by also providing social connections and reliable wellness information, which TSWs "may prioritize over HIV care" (Goldhammer et al., 2023). **Proposed Policies**

Policy	**Cost**	**Political opposition**	**Administrative feasibility**	**Efficacy**	**Scalability of benefits**	**Total (/25)**
Point-of-care HIV testing and treatment	3	3	4	5	4	**19**
Exit strategies for survival sex workers	5	2	3	5	2	**18**
Peer-to-peer health promotion in queer recreational	5	2	4	3	3	**17**

spaces						
LGBTQ+ community health centers	2	2	3	4	4	**15**

Scale: 1 (Poor) – 5 (Excellent)

Criteria and grading scale

Cost

Considers both the initial and ongoing costs relative to the potential for securing funding, as well as long-term cost-effectiveness and sustainability, through review of funding sources for the LDH and potential funding sources beyond traditional channels, such as public-private partnerships and community funding models.

Scale:

1: High initial and ongoing costs with challenging funding prospects.

2: Moderate costs, with potential funding sources identified but not secured.

3: Balanced cost, with a clear pathway to funding and evidence of cost-effectiveness.

4: Low cost, with secured funding.

5: Minimal cost, due to being volunteer-driven, revenue-generating, consolidating existing resources, and/or not affecting the legal economy.

Political opposition

Evaluates the level of support or resistance against a policy through review of laws, policies, case law, official positions, election campaigns, and/or current political climate as related to TSWs, SW, and LGBTQ+ issues; while taking into account the potential for change through advocacy and education.

Scale:

1: Strong resistance, with little to no foreseeable shift in stance.

2: Some resistance, but with identified pathways for increasing support.

3: Neutral stance, with potential for support through targeted advocacy; and/or conditional support that is applied to only some populations.

4: Moderate support, potentially influenced by public opinion and advocacy; and/or conditional support that is applied equally across all populations.

5: Strong support, with widespread political backing.

Administrative feasibility

Evaluates the likelihood of successful implementation, considering administrative capacity, projection of available resources, agency behavior, and/or ability to coordinate with necessary stakeholders or collaborators (the latter being especially applicable to evaluations of community-based, participatory interventions).

Scale:

1: Significant barriers to implementation, with little to no administrative capacity.

2: Some barriers present, with limited administrative flexibility.

3: Moderate feasibility, with challenges balanced by administrative capacity.

4: High feasibility, with strong administrative capacity and some precedent for similar initiatives.

5: Very high feasibility, with robust administrative support, clear precedents, and strong stakeholder engagement.

Efficacy

Estimates effectiveness in reducing HIV rates within TSW populations, based on empirical evidence and adaptability to local contexts, including generalization from queer to trans populations, cis women to trans women, and/or sex workers to specifically TSWs. Empirical

evidence in this context are quantitative and/or qualitative outcomes from meta-analysis of interventions aimed at decreasing HIV incidence and improvement of health outcomes.

Scale:

1: Little to no evidence of effectiveness.
2: Some evidence of effectiveness.
3: Moderate evidence of effectiveness, with limited potential for adaptation.
4: Strong evidence of effectiveness in similar contexts, with high adaptability.
5: Very strong evidence of effectiveness, with proven adaptability to a wide range of contexts.

Scalability of benefits

Assesses the direct and indirect benefits of the policy, considering both the target population and the wider community.

Scale:

1: Benefits limited to the target population.
2: Benefits the target group and highly marginalized, adjacent groups (i.e. SWs and/or trans people).
3: Benefits the below groups in addition to other marginalized groups at high risk of HIV (i.e. low income people, Black and Latinx people).
4: Broad benefits extending to various marginalized communities, including those not at high risk of HIV.
5: Universal benefits, significantly impacting the entire population.

Scores and context

The policy which scored the highest across the criteria was point-of-care HIV testing and treatment, with high scores particularly in efficacy (5) and administrative feasibility (4), reflecting its strong potential for immediate impact and manageable implementation. This makes sense, as integrating point-of-care HIV testing and treatment into community spaces has successfully increased rates of HIV and STI testing and treatment and patient retention.

The policy which scored the lowest was LGBTQ+ community (healthcare) centers, primarily due to significant political opposition and administrative challenges, making it less viable in Louisiana's current political climate. These are interesting results, considering that the best place for the former policy (as well as the second and third-place policies) to be implemented would be in institutions established by the policy ranking last. Previous research on peer-to-peer health promotion at queer-friendly sites of recreation, such as clubs and bars, showed moderate success. These interactions were random, in contrast to specialized spaces such as (LGBTQ) community centers with a self-selected clientele; the latter showed better rates of participation and retention. This inconsistency can then be understood primarily through the issue of precedence, since there is only a 4-point difference between the first and last ranks. Essentially, there is little to no precedent for LGBTQ+ community health centers in Louisiana, and none currently exist.

Political opposition has not yielded to advocacy, both in the above context and for any policies affecting queer and trans people, especially TSWs. Transphobia is deeply institutionalized in Louisiana: historical criminalization of SW disproportionately targeted Black and transgender sex workers; and recent legislation has restricted gender-affirming healthcare and defined transgender people by sex assigned at birth. Efforts to decriminalize SW have routinely failed as recently as 2021, with opposition from lawmakers, religious groups,

anti-trafficking organizations, and organizations representing DAs and sheriffs. Opposing groups both questioned whether women willingly chose SW as an occupation and argued it was impossible to separate SW from human trafficking, believing decriminalization would promote SW and endanger children. This argument, which is often made to justify transphobia, suggests that the significant political opposition to all above policies stems from their supposed 'promotion' of SW, RSBs, or queerness by virtue of addressing those specific health issues.

Policy Recommendation

Based on the above analysis, the policy recommendation is the establishment of "pop-up clinics" within existing community centers, operating 2-4 days a week. This model leverages the flexibility of pop-up clinics while ensuring they are a recurring and reliable presence within the community, rather than transient installations. These clinics serve as dedicated transgender community spaces for peer-to-peer health promotion and point-of-care HIV testing and treatment. This innovative approach leverages existing spaces, collaborating with community organizations to provide a less intimidating entry into sexual healthcare and risk behavior reduction methods. Unlike traditional community health centers, these pop-up clinics do not aim to offer generalized, trans-inclusive sexual healthcare. Instead, they focus on creating safe, designated spaces for gender-minority group congregation, akin to those available for sexual-minority communities. By integrating reliable wellness information and social connections into the healthcare process, these clinics are designed to meet the unique needs of the transgender community, enhancing accessibility to crucial health services while fostering a supportive environment.

Despite the low scoring of community health centers in the policy matrix, primarily due to high political opposition and significant barriers to implementation, the pilot program for trans

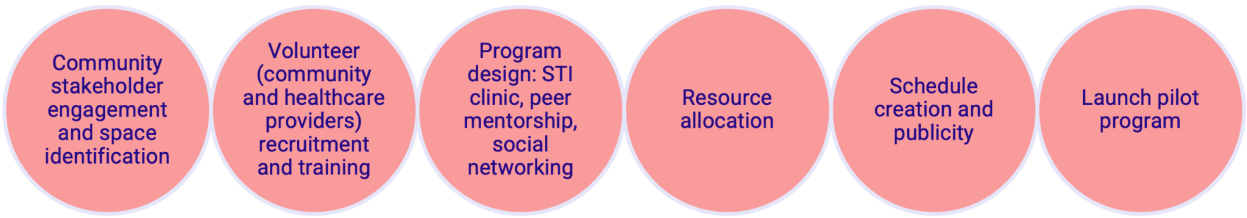
community spaces for peer-to-peer health promotion and point-of-care HIV testing and treatment presents a strategic alternative. This recommendation leverages existing spaces in collaboration with community organizations, thereby circumventing some of the systemic obstacles that new construction or formal health center establishments might face. Additionally, this approach allows for the tailoring of services to the specific cultural and social contexts of the target population, enhancing both the efficacy and acceptance of the services provided. Thus, this pilot program represents a pragmatic strategy for delivering controversial yet essential health services in a manner adaptable to the constraints imposed by sexual conservatism in Louisiana.

Limitations

While the recommended policy offers a targeted approach to reducing HIV rates among TSWs, potential challenges include fluctuating participation due to the proposed clinics potentially operating on an irregular schedule to accommodate the existing programs and schedules of the community centers housing them. (As an example, this may look like operating Monday-Wednesday one week and Thursday-Saturday the following week.) Moreover, community skepticism about health initiatives led by external organizations may persist even with close collaboration with TSW community leaders due to the history of overpolicing and criminalization of TSWs. To mitigate these challenges, the program will strive to maintain a consistent operation of 2-4 days a week within familiar community spaces and will communicate inconsistencies in days of operation well in advance, helping to build regular attendance and trust among TSWs. This communication will also emphasize the cost-benefit tradeoff of flexibility due to integrating these services into existing community centers and the sustainability of utilizing already established infrastructures and resources to counter concerns about the transient nature of pop-up models and promote integration of the initiative into the patient community's

routine, enhancing effectiveness and long-term viability. Furthermore, in addition to community leaders and organizations, patients will have the ongoing opportunity to participate in the planning and operation of these clinics to help alleviate skepticism and foster a sense of ownership and trust in the initiative.

Policy Implementation



Community stakeholder engagement and space identification

The first step in implementing a pilot program involves engaging with key community stakeholders to identify suitable locations for the pop-up clinics. This will be carried out by organizing meetings with local transgender advocacy groups, healthcare providers, and community leaders to understand the needs and preferences of the community. Spaces that are central, accessible, and considered safe by the community are ideal. Venues such as community centers, LGBTQ+ friendly cafes, or art spaces that are already frequented by the target demographic will be considered to ensure comfort and accessibility. Engaging community stakeholders not only helps in identifying appropriate spaces but also builds a sense of ownership and trust within the community, which is crucial for the success of the program.

Volunteer recruitment and training

Once spaces are identified, the next step is to recruit and train volunteers who will run the pop-up clinics. This involves reaching out to local medical schools, nursing programs, and

community organizations to find healthcare providers and community members interested in volunteering. Training will focus on specificity of healthcare needs of TSW patients, operational training on how to manage the pop-up clinic, and an overview of the health services to be provided. Emphasis will be placed on cultural competency and sensitivity to the unique social needs of patients ensuring that volunteers are prepared to provide respectful and informed care.

Program design

Designing the program involves detailed planning of the services offered at the pop-up clinics. Services will include STI testing and treatment, peer mentorship programs, and opportunities for social networking. The STI clinic will provide confidential and free testing and treatment services. Peer mentorship will involve experienced members of the transgender community guiding others, offering support, and sharing valuable resources and information. Additionally, the program will facilitate social networking events to strengthen community ties and provide a platform for sharing experiences and support, enhancing the overall resilience of the community.

Resource allocation

Resource allocation must be carefully planned to ensure that all aspects of the pop-up clinics are well-supported. This includes procuring medical supplies for STI testing and treatment, training materials for volunteers, and resources for social networking events. Budgeting will take into account the costs of venue rentals (if applicable), utilities, and promotional materials. Partnerships with local businesses and community organizations can also be explored to secure donations and sponsorships, reducing the financial burden on the program and fostering community involvement and support.

Schedule creation and publicity

Creating a detailed schedule for the operation of the pop-up clinics is essential. This includes the timing of clinic operations, volunteer shifts, and events. A consistent schedule helps in building regular attendance and reliability. Publicity is crucial to the success of the program. Outreach efforts will include social media campaigns, flyers in community hotspots, and collaborations with local influencers within the transgender community. The goal is to ensure that everyone who could benefit from the services knows when and where to access them. Publicity efforts will be sensitive to the privacy needs of the community members.

Pilot program launch

Official launch of the pilot program will begin with an inaugural event to introduce the program to the community, featuring talks from key stakeholders, testimonials from community members, and live demonstrations of health services offered. Regular feedback mechanisms will be established to assess the effectiveness of the program and make necessary adjustments, ensuring that the program remains responsive to the needs of the TSW community.

Timeline

Task	**Responsible parties**	**Start**	**End**
Community stakeholder engagement and space identification	Community relations team at LDH, local transgender advocacy groups		2025 Q1
Volunteer recruitment and training	Human Resources at LDH, volunteer coordination teams	2025 Q1	2025 Q2
Program design	Program development team at LDH, medical and peer support specialists, other community stakeholders	2025 Q1	2025 Q3

Resource allocation	Finance at LDH	2025 Q3	2025 Q4
Schedule creation and publicity	Marketing and public relations at LDH, scheduling coordinators	2025 Q3	2025 Q4
Pilot program launch	Entire project team		**2025 Q4**

Policy Evaluation

Patient baseline

Establishing a population baseline is crucial for measuring the effectiveness of the pilot program. Understanding the initial state of the community's health allows the program to tailor interventions specifically and measure changes over time, attributing shifts directly to program activities. Metrics will include rate of HIV prevalence, rate of new HIV infections, community health behaviors. These data will be collected from existing health records, surveys, and local health department databases to determine the current rates of HIV prevalence and new infections specifically within the transgender community in the target areas. This will also involve conducting initial surveys and focus groups to assess common health behaviors and attitudes towards health practices within the community.

Process metrics

Monitoring these metrics helps in assessing the reach and operational effectiveness of the program. Analyzing patient demographics ensures that the program is reaching the intended audience. Tracking service usage and patient retention helps in understanding the accessibility and ongoing relevance of the services provided, informing potential adjustments for improving patient engagement and satisfaction. Program metrics include number of HIV tests and treatment plans, patient demographics, service usage, patient retention and will be continuously gathered

through patient records and program data systems. This will include logging each HIV test conducted, treatments planned or initiated, detailed demographics of those served (age, gender identity, socioeconomic status), frequency of service usage, and retention rates over time.

Outcome metrics

Key performance indicators (KPIs) are vital for gauging the program's impact on health outcomes and behaviors. KPIs such as reduction in new HIV cases, reduction in RSB prevalence, and improvement in sexual health literacy are direct indicators of the program's effectiveness in mitigating HIV spread, modifying risky behaviors, and patient education. New HIV cases will be tracked via health department records and program data. Changes in RSB prevalence will be evaluated through follow-up surveys and interviews that explore behavior changes among participants. Health literacy improvements will be measured using pre- and post-intervention assessments designed to gauge participants' understanding of HIV, prevention strategies, and general health knowledge.

Specific targets for the above KPIs will be set based on the patient baseline data collected during the initial phase of the program and assessed through comparative analysis before and after the intervention. These targets will be aligned with an overarching goal of reducing HIV transmission by 20% and improving sexual health literacy by 30% among the TSW population within the first two years of program implementation. These figures are feasible and aligned interim targets, considering the broader state goals outlined in the LDH's 2022-2026 Louisiana HIV Prevention and Care Plan, which include 1) reducing new HIV infections by 75%; 2) increasing the availability of routine HIV testing by 30%; 3) increasing health-focused community event participation by 50%; 4) increasing the number of schools with majority Black, Latinx, or POC student bodies that provide age-appropriate, comprehensive sex education by

50%; and 5) having 90% of people living with HIV in Louisiana retained in care and with an undetectable viral load by December 2026. Setting specific, measurable targets for the recommended initiative not only aligns with state objectives, but also provides necessary accountability to TSW patients and improves the likelihood of patient trust and retention.

Qualitative feedback

This feedback is essential for understanding the subjective impact of the program and for gathering detailed insights that quantitative data alone cannot provide. It helps in identifying strengths and areas for improvement from the participants' perspectives, ensuring that the program remains responsive and relevant to the community's needs. Data will be collected through structured surveys, one-on-one interviews, and focus groups. These will be conducted periodically throughout the program to gather in-depth feedback on participants' experiences, perceptions of the program’s value, and personal stories of change.

Conclusion

If successfully implemented, the proposed policy centered on creating pop-up clinics within trans community spaces offers a multi-faceted approach to reducing the HIV burden among Louisiana TSWs. By directly addressing RSBsprevalent in this community, the policy aims to lower new HIV infection rates, thereby alleviating the long-term state burden of HIV/AIDS care. Furthermore, by enhancing sexual education and providing a structured platform for peer mentorship and health advocacy, the program expects to foster significant reductions in RSBs across the community. The introduction of gender-minority spaces not only serves as a sanctuary for congregation but also strengthens social networks, enhancing the community's resilience and capacity to advocate for their health effectively.

The ethos of harm reduction that underpins this policy acknowledges the complex socio-economic dynamics that drive SW. While it may not eliminate the economic motivations behind SW, the policy can vastly improve safety and health outcomes by equipping TSWs with the knowledge and tools to mitigate risks associated with their work. Over time, these harm reduction strategies may facilitate the development of viable exit strategies for TSWs, offering pathways out of sex work. As these community-specific interventions take root, they promise not only immediate health benefits but also the potential for transformative social change, aligning with broader public health goals and contributing to a more inclusive and supportive healthcare framework for marginalized populations.

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