Data Sources
The data contained in this report is compiled by the Texas Department of State Health Services; HIV/STD Branch.

Data sources include: Enhanced HIV AIDS Reporting System (as of July 2, 2017), Medicaid, ARIES (Ryan White Program database), ADAP (AIDS Drug Assistance Program), STD*MIS (Prevention and Public Health Follow Up database), the Texas Medical Monitoring Project and private insurance data.

Terminology & Abbreviations
PLWH—People Living With HIV
HSDA—HIV Service Delivery Area (based on HIV Care & Treatment funding)
Mode of Exposure—How a person acquired HIV—a person’s biological sex (i.e. sex assigned at birth) is used to determine mode of exposure

- Male-Male Sexual Contact—HIV acquisition most likely occurred due to sexual contact between two men
- Injection Drug Use—HIV acquisition most likely occurred due to injection drug use
- Male-Female Sexual Contact—HIV acquisition most likely occurred due to sexual contact between a man and a woman.

Priority Populations—Populations who are disparately and disproportionately impacted by HIV
Latinx—a gender neutral term used in place of Latino or Latina
Latinx MSM—Latino gay, bisexual and other cisgender Men who have Sex with Men
White MSM—White gay, bisexual and other cisgender Men who have Sex with Men
Black MSM—Black gay, bisexual and other cisgender Men who have Sex with Men
Black Women—Black cisgender Women who have sex with men
Transgender People—includes both transgender men and transgender women. A significant majority of Transgender PLWH are transgender women.
Latinx Women—Latina cisgender Women who have sex with men
PWID—People Who Inject Drugs
PrEP—Pre-Exposure Prophylaxis—HIV Prevention Medication
nPEP—non-occupational Post-Exposure Prophylaxis
Behavioral Interventions—interventions designed to change behaviors that make people more vulnerable to acquiring HIV. These can include individual, group and community level interventions.
Retention in Care—2 contacts with the care system, at least 3 months apart in the calendar year (contacts include a visit with a medical provider, HIV lab work, or and ART prescription)
Viral Suppression—a viral load <= 200 copies/ml
In-Care Viral Suppression—Viral Suppression among PLWH who have achieved Retention in Care
People Living With HIV (PLWH) and New HIV Diagnoses

In Texas, the number of new HIV diagnoses has remained flat and stable for the past several years.

There were **94,106 people living with HIV (PLWH)** in this area as of the end of 2018. In 2018, **4,410 people were newly diagnosed with HIV**. This includes only people with diagnosed HIV with a current address in this area. People with undiagnosed HIV are not included.

Priority Populations (68% of PLWH, 75% of New HIV Diagnoses)

Priority populations make up the majority of PLWH and the majority of new diagnoses. Latinx MSM are the largest priority population among PLWH and among new HIV diagnoses.
Gender
Males make up the majority of PLWH and the majority of new HIV diagnoses.

*Note*
Due to current reporting methods, the number of transgender PLWH are most likely underreported.

Mode of Exposure
Male-Male Sexual Contact makes up the primary mode of acquisition among PLWH and among new diagnoses.

Age
The majority of PLWH are people 45-64; the majority of new diagnoses are among people 25-45.

Race/Ethnicity
The majority of PLWH are Black and the majority of new diagnoses are among Latinx individuals.
Focused Prevention

Focused Prevention involves ensuring that HIV prevention efforts are centered around those populations and communities where HIV is most heavily concentrated. These populations are often disparately impacted by HIV and any efforts to significantly reduce new HIV incidence must focus on meeting the needs of these groups. Focused Prevention interventions are based on the concept of Combination Prevention. Combination Prevention values client autonomy and includes Behavioral Interventions, Condoms/Lubricant, HIV/STI Testing, and Biomedical Interventions like PrEP, nPEP and Treatment as Prevention (TasP).

Texas’ goal is that all people with increased vulnerabilities to acquiring HIV have equitable access to Combination Prevention.

Statewide Relevant Populations for Prevention

In Texas, HIV prevention efforts should be centered around these populations:

- Latinx MSM
- White MSM
- Black MSM
- Black Women
- Transgender People

Prevention Interventions—DSHS Funded (see Appendix A for intervention descriptions)

- Routine HIV Screening in Health Care Settings
- Core HIV Prevention
- PrEP and nPEP
- Client Level Interventions
- Structural Intervention
**Full Diagnosis**

*Texas’ goal is that 90% of all PLWH know their status by 2030.*

**Primary Diagnosing Facilities 2013-2018**

*These are the top 10 diagnosing facilities in the state*

<table>
<thead>
<tr>
<th>Diagnosing Facility</th>
<th>Total # Diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legacy CHS—Houston</td>
<td>666</td>
</tr>
<tr>
<td>Houston Health Clinic</td>
<td>598</td>
</tr>
<tr>
<td>Parkland Memorial Hospital—Dallas</td>
<td>592</td>
</tr>
<tr>
<td>Resource Center—Nelson-Tebedo—Dallas</td>
<td>516</td>
</tr>
<tr>
<td>Dallas Co HHS—STD Clinic</td>
<td>514</td>
</tr>
<tr>
<td>San Antonio Metro HD—STD Clinic</td>
<td>431</td>
</tr>
<tr>
<td>Ben Taub GH—Houston</td>
<td>427</td>
</tr>
<tr>
<td>Parkland—ER—Dallas</td>
<td>361</td>
</tr>
<tr>
<td>LBJ Hospital—Houston</td>
<td>276</td>
</tr>
<tr>
<td>Hospital District Clinic—Houston</td>
<td>270</td>
</tr>
</tbody>
</table>

**Late Diagnosis 2014—2017**

*A “late diagnosis” is when a person receives a Stage 3/AIDS diagnosis within 3 months of their initial HIV diagnosis. Studies have linked late HIV diagnoses to slower CD4 gains, faster disease progression and higher mortality.*

Late diagnoses among Black Women have been decreasing over the past few years.
**Successful Linkage**

We know that treatment for HIV keeps PLWH healthier longer and reduces deaths, but it is most effective if treatment starts soon after the diagnosis is made. Linkage refers to the time it takes from the person’s diagnosis to when they have their first episode of HIV medical care.

*Texas’ goal is for 90% of all people newly diagnosed with HIV to be linked to care within 3 months.*

**Timely Linkage—2017**

80% of people diagnosed with HIV in Texas in 2017 were linked to care within 3 months.

*Linkage to care is a priority*

![Pie chart showing linkage distribution](chart.png)

<table>
<thead>
<tr>
<th>Linkage Duration</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linked in 1 month</td>
<td>2,733</td>
<td>62%</td>
</tr>
<tr>
<td>Linked in 2-3 months</td>
<td>797</td>
<td>18%</td>
</tr>
<tr>
<td>Linked in 4-12 months</td>
<td>309</td>
<td>7%</td>
</tr>
<tr>
<td>Linked in 12+ months</td>
<td>15</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>No Evidence of Linkage</td>
<td>556</td>
<td>13%</td>
</tr>
</tbody>
</table>

**Timely Linkage—Priority Populations—2012-2017**

*Coming Soon*
Retention in Care and Viral Suppression are two key measures that help us understand individual level health, efficacy of HIV care systems, and Community Viral Load. **Retention in Care** is defined as at least 2 contacts with the care system during the year (either an HIV medical appointment, HIV lab work, or an ART prescription). **Viral Suppression** is defined as a viral load that’s less than/equal to 200 copies/ml. For these purposes we’re looking at the last viral load of the year.

**Studies have shown that PLWH who are able to maintain viral suppression (for at least 6 months) can not transmit HIV.**

Health Outcomes—**Stoplight System**

*Texas’ goals by 2030 are:*

<table>
<thead>
<tr>
<th>90%</th>
<th>PLWH retained in HIV care &amp; treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>of those retained achieve viral suppression</td>
</tr>
</tbody>
</table>

Communities and populations are prioritized using the following color coding system:

- **On ART / Retention In Care**
  - **< 69%**
    - Stop and examine further, May be a priority
  - **70% - 89%**
    - May need to examine further, May not be a priority
  - **90%**
    - Maintain Current Activities, Look for Promising Practices

- **On ART/In-Care Viral Suppression**
  - **< 84%**
    - Stop and examine further, May be a priority
  - **85% - 89%**
    - May need to examine further, May not be a priority
  - **90%**
    - Maintain Current Activities, Look for Promising Practices
2018 Care Continuum

In Texas, 70% of PLWH have achieved retention in care, 61% of total PLWH have achieved viral suppression, and 86% of PLWH who are retained in care achieved viral suppression. Retention in care is a priority area for the overall state.

77% of PLWH had at least 1 episode of HIV care & treatment. This means roughly 8 out of 10 PLWH were in care.

61% of PLWH achieved viral suppression (last viral load of the year was <200 copies/ml). This means 6 out of 10 PLWH achieved viral suppression. This is community viral suppression.

70% of PLWH were retained in care (at least 2 episodes of HIV care & treatment across the year). This means 7 out of 10 PLWH were retained in care.

Of those 7 out of 10 PLWH retained in care, 86%, or roughly 6 of those 7 achieved viral suppression. This is in-care viral suppression.
**2018 Continuum of Care, Parity Table**

Communities with the fewest opportunities to achieve retention are people under the age of 45, PWID, Latinx PLWH, people who acquired HIV through male-female sexual contact and Black PLWH, specifically Black MSM And Black Women.

The communities with the fewest opportunities to achieve viral suppression even when retained in care are people under the age of 45, Transgender PLWH, Women, people who acquired HIV through male-female sexual contact, and Black PLWH, specifically Black MSM, Black Women.

People over the age of 65 White MSM and Latinx MSM have achieved In-Care Viral Suppression goals.

---

<table>
<thead>
<tr>
<th>PLWH retained in HIV care &amp; treatment</th>
<th>% of those retained achieve viral suppression</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>90%</strong></td>
<td><strong>90%</strong></td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th></th>
<th>PLWH</th>
<th>Evidence of Care (At least one visit)</th>
<th>Retained in Care</th>
<th>Suppressed</th>
<th>% suppressed of those retained</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>All PLWH</td>
<td>94,106</td>
<td>100%</td>
<td>72,306</td>
<td>77%</td>
<td>66,255</td>
</tr>
<tr>
<td>Women</td>
<td>19,821</td>
<td>21%</td>
<td>15,299</td>
<td>77%</td>
<td>13,990</td>
</tr>
<tr>
<td>Men</td>
<td>73,462</td>
<td>78%</td>
<td>56,304</td>
<td>77%</td>
<td>51,618</td>
</tr>
<tr>
<td>Transgender People</td>
<td>823</td>
<td>1%</td>
<td>703</td>
<td>85%</td>
<td>647</td>
</tr>
<tr>
<td>White</td>
<td>22,895</td>
<td>24%</td>
<td>18,538</td>
<td>81%</td>
<td>17,328</td>
</tr>
<tr>
<td>Black</td>
<td>34,648</td>
<td>37%</td>
<td>25,981</td>
<td>75%</td>
<td>23,217</td>
</tr>
<tr>
<td>Latinx</td>
<td>31,643</td>
<td>34%</td>
<td>23,715</td>
<td>75%</td>
<td>21,972</td>
</tr>
<tr>
<td>&lt;=24</td>
<td>3,953</td>
<td>4%</td>
<td>3,074</td>
<td>78%</td>
<td>2,531</td>
</tr>
<tr>
<td>25 – 44</td>
<td>40,360</td>
<td>43%</td>
<td>30,577</td>
<td>76%</td>
<td>27,216</td>
</tr>
<tr>
<td>45-64</td>
<td>43,759</td>
<td>46%</td>
<td>34,231</td>
<td>78%</td>
<td>32,258</td>
</tr>
<tr>
<td>65+</td>
<td>6,034</td>
<td>6%</td>
<td>4,424</td>
<td>73%</td>
<td>4,250</td>
</tr>
<tr>
<td>Male-Male Sexual Contact</td>
<td>57,602</td>
<td>61%</td>
<td>44,957</td>
<td>78%</td>
<td>41,246</td>
</tr>
<tr>
<td>Injection Drug Use</td>
<td>13,654</td>
<td>15%</td>
<td>10,146</td>
<td>74%</td>
<td>9,275</td>
</tr>
<tr>
<td>Male-Female Sexual Contact</td>
<td>21,853</td>
<td>23%</td>
<td>16,514</td>
<td>76%</td>
<td>15,102</td>
</tr>
<tr>
<td>White MSM</td>
<td>16,577</td>
<td>18%</td>
<td>13,667</td>
<td>82%</td>
<td>12,869</td>
</tr>
<tr>
<td>Black MSM</td>
<td>16,084</td>
<td>17%</td>
<td>12,015</td>
<td>75%</td>
<td>10,571</td>
</tr>
<tr>
<td>Latinx MSM</td>
<td>21,309</td>
<td>23%</td>
<td>16,256</td>
<td>76%</td>
<td>15,038</td>
</tr>
<tr>
<td>Black Women</td>
<td>9,158</td>
<td>10%</td>
<td>7,023</td>
<td>77%</td>
<td>6,342</td>
</tr>
<tr>
<td>Transgender Women</td>
<td>800</td>
<td>1%</td>
<td>687</td>
<td>86%</td>
<td>632</td>
</tr>
</tbody>
</table>

*Note*

Data sets representing PLWH who are in-care are most often used to confirm gender identity for transgender PLWH. Because of this, the percentage of transgender PLWH who have achieved retention in care may be over-represented here.
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2018 Continuum of Care, Priority Populations by age, Stoplight System

Retention in Care, Priority Populations

In-care Viral Suppression, Priority Populations

Data sets representing PLWH who are in-care are most often used to confirm gender identify for transgender PLWH. Because of this, the percentage of transgender PLWH who have achieved retention in care may be over-represented here.
Retention in Care, Priority Populations

In-Care Viral Suppression, Priority Populations

*Note*

Data sets representing PLWH who are in-care are most often used to confirm gender identity for transgender PLWH. Because of this, the percentage of transgender PLWH who have achieved retention in care may be over-represented here.
**Percent Retained in Care by HSDA Texas, 2018**

**Percent Retained in Care**

- Red: ≤ 69%
- Yellow: 70% - 89%
- Green: ≥ 90%

*People living with HIV who have had two labs, visits or ARVs more than 3 months apart in 2018.

Statewide average = 70%

Source: Texas eHARS, 2019

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**Percent Virally Suppressed from Retained in Care by HSDA Texas, 2018**

**Percent Virally Suppressed**

- Red: <85%
- Yellow: 85% - 89%
- Green: ≥ 90%

*Last viral test value in 2018 ≤ 200 copies /mL.

Statewide average = 86%

Source: Texas eHARS, 2019
**Targets**

*The number of people who need to be able to access and engage with our systems in order to equitably meet our 90-90 goals (based on current number of PLWH who know their status).*

<table>
<thead>
<tr>
<th>PLWH</th>
<th>Retained in Care</th>
<th>90% Retained goal</th>
<th>Gap</th>
<th>Suppressed</th>
<th>90% In-Care Viral Suppression goal</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>All PLWH</td>
<td>94,106 (100%)</td>
<td>66,255 (70%)</td>
<td>84,695</td>
<td>18,440</td>
<td>57,251</td>
<td>76,226</td>
</tr>
<tr>
<td>Women</td>
<td>19,821 (21%)</td>
<td>13,990 (71%)</td>
<td>17,839</td>
<td>3,849</td>
<td>11,799</td>
<td>16,055</td>
</tr>
<tr>
<td>Men</td>
<td>73,462 (78%)</td>
<td>51,168 (70%)</td>
<td>66,116</td>
<td>14,498</td>
<td>44,939</td>
<td>59,504</td>
</tr>
<tr>
<td>Transgender People</td>
<td>823 (1%)</td>
<td>647 (79%)</td>
<td>741</td>
<td>94</td>
<td>513</td>
<td>667</td>
</tr>
<tr>
<td>White</td>
<td>22,895 (24%)</td>
<td>17,328 (76%)</td>
<td>20,606</td>
<td>3,278</td>
<td>15,493</td>
<td>18,545</td>
</tr>
<tr>
<td>Black</td>
<td>34,648 (37%)</td>
<td>23,217 (67%)</td>
<td>31,183</td>
<td>7,966</td>
<td>19,182</td>
<td>28,065</td>
</tr>
<tr>
<td>Latinx</td>
<td>31,643 (34%)</td>
<td>21,972 (69%)</td>
<td>28,479</td>
<td>6,507</td>
<td>19,392</td>
<td>25,631</td>
</tr>
<tr>
<td>&lt;=24</td>
<td>3,953 (4%)</td>
<td>2,531 (64%)</td>
<td>3,558</td>
<td>1,027</td>
<td>2,066</td>
<td>3,202</td>
</tr>
<tr>
<td>25 – 44</td>
<td>40,360 (43%)</td>
<td>27,216 (67%)</td>
<td>36,234</td>
<td>9,108</td>
<td>22,804</td>
<td>32,692</td>
</tr>
<tr>
<td>45-64</td>
<td>43,759 (46%)</td>
<td>32,258 (74%)</td>
<td>39,383</td>
<td>7,125</td>
<td>28,452</td>
<td>34,445</td>
</tr>
<tr>
<td>65+</td>
<td>6,034 (6%)</td>
<td>4,250 (70%)</td>
<td>5,431</td>
<td>1,181</td>
<td>3,929</td>
<td>4,888</td>
</tr>
<tr>
<td>Male-Male Sexual Contact</td>
<td>57,602 (61%)</td>
<td>41,246 (72%)</td>
<td>51,842</td>
<td>10,596</td>
<td>36,549</td>
<td>46,658</td>
</tr>
<tr>
<td>Injection Drug Use</td>
<td>13,654 (15%)</td>
<td>9,275 (68%)</td>
<td>12,288</td>
<td>3,013</td>
<td>7,396</td>
<td>11,059</td>
</tr>
<tr>
<td>Male-Female Sexual Contact</td>
<td>21,853 (23%)</td>
<td>15,102 (69%)</td>
<td>19,668</td>
<td>4,556</td>
<td>12,918</td>
<td>17,701</td>
</tr>
<tr>
<td>White MSM</td>
<td>16,577 (18%)</td>
<td>12,869 (78%)</td>
<td>14,920</td>
<td>2,051</td>
<td>11,742</td>
<td>13,428</td>
</tr>
<tr>
<td>Black MSM</td>
<td>16,084 (17%)</td>
<td>10,571 (66%)</td>
<td>14,476</td>
<td>3,905</td>
<td>8,839</td>
<td>13,028</td>
</tr>
<tr>
<td>Latinx MSM</td>
<td>21,309 (23%)</td>
<td>15,038 (71%)</td>
<td>19,178</td>
<td>4,140</td>
<td>13,495</td>
<td>17,260</td>
</tr>
<tr>
<td>Black Women</td>
<td>9,158 (10%)</td>
<td>6,342 (69%)</td>
<td>8,243</td>
<td>1,901</td>
<td>5,334</td>
<td>7,419</td>
</tr>
<tr>
<td>Transgender Women</td>
<td>800 (1%)</td>
<td>632 (79%)</td>
<td>720</td>
<td>88</td>
<td>498</td>
<td>648</td>
</tr>
</tbody>
</table>

*Note*

Data sets representing PLWH who are in-care are most often used to confirm gender identity for transgender PLWH. Because of this, the percentage of transgender PLWH who have achieved retention in care may be over-represented here.
Appendix A: Prevention Interventions

The following are brief overviews of DSHS funded HIV prevention activities. With the exception of Routine HIV Screening in Health Care Settings, all prevention activities are focused on populations who have increased vulnerabilities to acquiring HIV. See the Focused Prevention section for locally relevant populations who are appropriate for Focused Prevention activities.

Routine Screening in Health Care Settings

The CDC recommends that everyone between the ages of 13 and 64 get tested for HIV at least once as part of routine health care and those with increased vulnerabilities to HIV (including gay, bisexual and other men who have sex with men) get tested more frequently. DSHS funded Routine Screening programs are opt-out testing programs and can be found in a variety of facilities, including hospital emergency departments, community health centers, and jail medical services.

Activities conducted in Routine Screening programs must include:

- Routine HIV screening and notification of HIV-positive results; and
- Linkage to and engagement in HIV medical care for people with HIV-positive test results

More information on evidence-based linkage programs can be found at the CDC in the Compendium of Evidenced-Based Intervention and Best Practices for HIV Prevention

Core HIV Prevention

Core HIV Prevention programs must include the following activities:

- Engaging populations with increased vulnerability to HIV
- Condom distribution
- Focused HIV and syphilis testing in non-clinical settings (emphasis on locations with high probability of encountering the locally relevant population for focused prevention)
- Linkage to and engagement in HIV medical care for people with HIV-positive test results; and
- Referral to PrEP, nPEP and other needed services for people with HIV-negative test results and increase vulnerabilities to acquiring HIV

More information on evidence-based linkage programs can be found at the CDC in the Compendium of Evidenced-Based Intervention and Best Practices for HIV Prevention
PrEP and nPEP

The CDC states that when taken daily, PrEP is highly effective for preventing HIV. Studies have shown that PrEP reduces the risk of getting HIV from sex by about 99% when taken daily. Among people who inject drugs, PrEP reduces the risk of getting HIV by at least 74% when taken daily.

PEP is also highly effective at preventing HIV. PEP is the use of antiretroviral drugs after a single high-risk event to stop HIV seroconversion. PEP must be started as soon as possible to be effective—and always within 72 hours of a possible exposure.

Activities conducted in PrEP and nPEP programs must include:

- Promotion and marketing of PrEP/nPEP through community education and awareness activities
- Promotion of adoption of PrEP/nPEP by local clinical providers; and
- Delivery of PrEP/nPEP clinical and client support services (this funding may not be used to pay for PrEP/nPEP medications, but it may be used for: navigation staff, clinical staff, initial and ongoing medical testing, adherence counseling and benefits counseling.

Client Level Interventions

Client Level Interventions are evidence-based or practice-based behavioral interventions delivered to individuals or groups that have shown effectiveness in preventing HIV transmission and acquisition. These interventions may be focused on both PLWH or HIV-negative people with increased vulnerabilities to acquiring HIV. Programs funded through DSHS may use approved “homegrown” interventions, or one of the CDC interventions listed in the Compendium of Evidenced-Based Intervention and Best Practices for HIV Prevention.

Currently funded interventions in Texas include:

- Healthy Relationships
- Personalized Cognitive Counseling
- CLEAR
- Many Men, Many Voices
- Behavioral Health
- Connect
- ¿Y Ahora Que?
- VOICES/VOCES
Appendix A: Prevention Interventions, continued

**Structural Interventions**

Structural interventions are projects implemented at the community or system level in order to reduce the risk of HIV transmission and acquisition. These programs must work to reduce health inequities, and new HIV infections by directly addressing the social determinants of health such as stigma, lack of support, or policies or organizational practices that create barriers to prevention and treatment. Activities must be centered on one or more of the outcomes below:

- Strengthening community involvement in HIV prevention efforts by increasing a sense of community ownership, participation, and collaboration in HIV prevention activities;
- Increasing local coordination and collaboration among community members, groups, organizations, and sectors (e.g., private business, public institutions);
- Increasing community support, education, and dialogue;
- Creating an environment in which people of color, LGBTQ individuals, youth, and other marginalized populations are empowered to reduce the risk of HIV acquisition and barriers to accessing HIV prevention are reduced/eliminated;
- Elimination of structural, social, and economic barriers related to healthcare;
- Improved health outcomes for LGBTQ communities and people of color; and
- Increased participation in HIV-related care and PrEP\nPEP.

Programs may use ‘traditional’ community-level interventions as part of their structural intervention. Programs funded through DSHS may use approved “homegrown” interventions, or one of the CDC interventions listed in the *Compendium of Evidenced-Based Intervention and Best Practices for HIV Prevention*, or one of the Community and Structural-level interventions found on the CDC’s *Effective Interventions*.

Currently funded interventions in Texas:

- MPowerment
- Stigma Reduction
- Community PROMISE
- Addressing Stigma