00:00:00 **Laura Browder:** Perfect.

Elaine Martin: Let me just grab my questions.

LB: Oh yeah. Grab your questions.

EM: I don't know what category I really fit in in here so…

LB: I was thinking about that on the drive over.

EM: 'Cause I'm not a health care provider, nor an activist.

LB: Neither fish nor fowl, but…

EM: Right. But I sort of answered the health care provider questions. It was the closest. So…

LB: That's what I thought. So I'm gonna ask you to hold this mic if that's okay.

EM: That close enough?

LB: That's perfect. Just like you're about to eat an ice cream cone.

EM: Great.

LB: So Elaine, why don't we start off with you just telling me something about where you're from, how you grew up, family, childhood, all of that good stuff.

EM: Okay. I would say that I am a child of the North but have lived most of my life in the South. So my parents were from New York and Pennsylvania, but my dad was a Navy guy. So we moved around a lot in my childhood—Florida, Texas, and finally landed in Virginia. But I sort of grew up with a northern household mentality. But have always lived in the South. So I guess I bring a different perspective maybe than most people have in Richmond. But I moved to Richmond in 1986 to go to graduate school, and I stayed. I've actually lived in Richmond longer than I've lived anywhere else, so this is truly my hometown.

LB: So I'm guessing you were going to VCU…

EM: Actually University of Richmond.

LB: Oh! University of Richmond?

EM: Yeah.

LB: Okay. And what were you studying?

EM: I got my master's degree in psychology there.

LB: Interesting.

EM: I was planning on getting a PhD and becoming a clinical psychologist but I got waylaid by this public health thing. I was in Richmond and I needed a job to help pay my way through school and I saw an ad in the paper for hotline counselors for the AIDS hotline. I knew something about HIV just because I had friends in the gay community. And I had already done some crisis counseling. I took a year off between college and graduate school and I worked on a crisis hotline as a volunteer for a year, so I had crisis counseling experience. I applied for the job and I was supposed to work ten hours a week. And I had another part-time job and my first day they're like, "Can you work forty hours a week? We really need somebody to do x, y, and z." The next thing you know I stayed. Then I thought, "Oh well I'll just stay 'til I'm done with school." And then it became my career and actually kind of my calling I would say, definitely.

I found I was in the right place. I think that the whole social justice is important to me and there's certainly a huge role for that in HIV. The fact that I was comfortable working with gay men and injection drug users, I think, was really helpful… coming from kind of a nonjudgmental place. My original intent to work in psychology, I think, was also born out as well. A lot of the work we do around behavior change and behavioral interventions is based on psychological theory so I was like, "Oh, oh, I'm in the right place." But I really had a lot of on-the-job training. I didn't know a lot about public health when I got here. But there were maybe a handful of people working in HIV, like less than five, when I arrived. I was mostly the division… it was originally… the sign on the door was the "Bureau of Venereal Disease Control." We still had an old sign up although I think they had changed the name to STD by then. But I learned everything here on-the-job, within my first few weeks I was assisting with reviewing potential cases. I was assisting with maintaining counseling and testing data for the state. Then they handed me some papers and said, "Write a grant." And I was like, "A what?" People coming into the job now, 'cause we still have the hotline…they're actually right next to me…they don't quite get that same breadth of experience that I got because there was literally nobody else to do stuff. So you just dug in and learned it. I got a really great public health education. Not by getting a master's in public health but just by being immersed in it and really working in all aspects of prevention and surveillance and care. That gave me just a whole different way that I kind of came into the system. Back in the 80s no one was really that enthused to work in HIV in public health so there was definitely that opportunity. There certainly weren't more experienced people who would've competed with me for the job, because nobody had experience in HIV. It was a very interesting thing to come in at the very beginning when things were just starting…and then see how they progressed for… I've been here thirty-one years here now. Never imagined I would be here thirty-one years later.

LB: So what drew you to HIV work?

EM: I think that I have always been somebody who was supporting the underdog. It's just always been like… You know, you watch the Olympics, and I'm always rooting for that little country that's not supposed to get a medal to get the medal, you know? And then when they win I'm crying. I think I've just always been a champion of the underdogs. It's just my personality. I think HIV has always been an underdog and the people affected by HIV have always been

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stigmatized populations. I was at an STD conference one time and they talked about: "Why are we in this work?" They said, "People who go into this work want the world to be more fair." I think that's always been my life plan. I want things to be fair. When I was a little kid I'd be like, "It's not fair." I think I'm still that person who says, "But it's not fair!" So searching for fairness in the world and it just really seemed like a cause that other people didn't care about. That's what made me jump into it. And then I've always had a lot of gay friends. I did theater in high school and college. Of course I met gay people through that venue. It just seemed like a really natural fit for me for some reason. I just like to champion the difficult causes.

LB: When did you first hear about AIDS? Do you remember that?

EM: I do. It probably was like '83 maybe? I was at a friend's house and it happened to be… it was the local gay newspaper at the time in Norfolk, Virginia. There was an article that they were reprinting from either the New York Times or something like that about this "new, gay disease," called "AIDS" or "GRID" or I don't even know if they called it AIDS then. So I was aware of it because of that and so had sort of followed along with what was going on in the early days.

LB: Were you having friends who were affected early on?

EM: Not early on. Later on I found out that some of my friends were affected but not when I started working in it. I didn't personally know anybody who was HIV-positive when I started working in HIV. But it turned out that one of my best friends from high school ended up being HIV-positive. He got diagnosed a few years later. Some people, I learned down the line, had also been affected. But I didn't know that at the time.

LB: So a lot of your direct experience, it sounds like, was coming through your hotline work.

EM: Yes, definitely. The hotline in the early days was… We had a lot of calls and there was a lot of really worried people. We had a lot of the worried well people, and then you saw a lot of the stigma. We would get questions like, "Oh, my brother just came to visit my house for the weekend and he's gay. Do I need to steam clean the carpets?" and "My son has moved back in with us and he has AIDS, and no one will eat off the same plate so we have a separate plate and utensils for him." We don't tend to get those kind of questions now, but we certainly did in the early days. We didn't have a lot of treatment options, so it was definitely a much more grim time.

LB: What was the evolution that you saw from those very early days of: "Do we need to steam clean the carpet because someone who's gay is coming over?"… to what happened next and where we are now?

EM: I think that the advent of a good test was one thing. In '85 we started testing. The test became available. Virginia was actually the first state that did testing in its STD clinics in 1978 to go…like complete…like nobody knows that! But there it is. So first state-wide clinic STD testing. And then you had a test, but what about treatment? So then treatment came on board. But still the early years were really just about trying to keep people alive and provide them with dignity while they died, essentially. Then with the advent, in the mid 90s, when we had

combination therapy, that's when I think the tide really started to turn in terms of—it's not just people preparing for death and helping them have a good death. This is about helping people live. And then I think the next evolution came around when they discovered treatment as prevention. If you have an undetectable viral load, if you're virally suppressed, then you can't transmit the virus. The importance of keeping people on treatment became… to me it's like a win-win because it's good for individual health, but it's also good for public health because we're preventing disease to the next person. Sometimes individual health and public health clash. In this case they don't—which is really great. I think that was the next evolution. And then I think the last one has been the emergence of PREP, so the daily pill to prevent HIV. We've been working really hard the past two years getting PrEP up and running. So many people I talk to still say, "There's a pill? You can prevent HIV? I had no idea." I'm like, "Really? We're telling everybody we can but people—they hear it but they don't believe it." Or they hear it and they're just like, "I just never heard that before." I think between treatment and prevention is PREP. For the first time we're really saying, "Oh, I think it really could be possible to end the epidemic if we can get people tested and we can then either get them onto PrEP or get them onto treatment and use all our tools we already have like condoms and interventions and behavior change and put all that together." It's the best package we've ever had in terms of extending people's lives and preventing new infections.

LB: Yeah. Sarah Monroe, who I'm sure you know, said to me that we could end AIDS today…which shocked me.

EM: Yeah.

LB: Because most people don't think of it that way.

EM: Right. There's always an issue with people dropping out of care for various reasons. Sometimes people…they just don't feel sick. They don't wanna think about HIV. If I take a pill every day—I have to think about it. Or they had a bad encounter with a healthcare provider, or they lost their insurance and they don't realize—"Oh well we have programs to help people that don't have insurance." There's many, many, many reasons why people don't stay engaged in care. That's another one of our big efforts is to find those people, get them back into care, and make sure people make that connection between testing and getting treatment.

LB: I'm still fixated a little bit on you telling me that in 1987, Virginia was the first state to do testing in the STD clinics.

EM: Mhm.

LB: And yet I think of Virginia as such a conservative state…

EM: Right.

LB: …sexually speaking. Right? How do you explain that? What was that all about?

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EM: Well I think it's because it wasn't about… It was about testing for STDs. And I think testing for STDs is always something that's been used as the… "We can't find disease and eradicate and treat it unless we have a test." It wasn't… I don't think that was a hard sell politically. I think, in fact, maybe the fact they're conservative is maybe we need to know who's infected, who's out there.

LB: So we think.

EM: So maybe that's the reason. I don't know. But also our HIV director at the time was a long-term CDC/STD guy. I think that that's where he saw the natural fit to get testing going.

LB: That's interesting. Clearly it's been a huge evolution, right? On every front in the treatment of HIV.

EM: Absolutely.

LB: What are some of the biggest challenges that you faced? And can you tell me about some of your turning points over the last thirty-one years?

EM: Sure. Yeah. So I think, certainly, the wave of politics; it ebbs and flows and it always seemed that when we had a conservative governor in Virginia, then we would have a more liberal President of the United States, and vice versa, we'd get a conservative president, we'd have a liberal governor. Some of our challenges were like, "Well we could do this but the state won't let us," or, "We could do this but the feds won't let us." So we rarely had both of those at the same time where we had kind of a more liberal approach about what was going on in the governor's mansion, and what was going on at the CDC. There were times in the past we weren't allowed to use the word "condoms" in a grant application. So we called them "risk protection devices." We were still giving them out, but, as I said, "I'll call them whatever you want as long as I can still do my programs." We've definitely had some challenges where there were activities and programs that we wanted to do that we couldn't. Sometimes we could just funnel it through community-based organizations, and sometimes we could not. I think what's been most apparent in the past—I wouldn't say currently—is just what we could say in a media campaign. That was very, you know, the media company would come up with and say, you know, "This is what the audiences respond to but we couldn't get it approved." So that would be challenging. But it made us creative. It's like, "If we can't get it done this way, how else can we get this done?" I think we would just always go back to the drawing board and say, you know, "What else can we try to do?

LB: So what kinds of programs, over the years, were you unable to implement that you really wanted to? What were some of the ones that got away? Because of the political landscape?

EM: Until recently, we have been prohibited from doing syringe services in Virginia. And the legislation was passed. That became effective in July of 2017. Now I thought I would end my career and retire without ever seeing syringe services happen in Virginia. But it did. I think that was the big push because of the opioid epidemic. Without that big increase in cases in Hepatitis C—I don't think we would've gotten the political will to make that happen. So that's been very exciting. And it was also prohibited by the federal government for a long time. And then they

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said we could. And then *they* said we couldn't. And now we can again. So it goes back and forth both from the feds and the state. But you know the federal government you're not allowed to use all those moneys to purchase syringes themselves, or needles, so you have to find another funding source. And the state would also prefer that we do not use state money for that purpose. So we've gotten some foundation grants from AIDS United that will help with that issue. So we're hoping our first syringe services site is opening this month in Wise County. And we have an application from Health Brigade in Richmond and that one should be authorized soon. I was extremely satisfied to see that finally come about.

Some of our work with gay men has been questioned. A few years ago we were supporting some HIV-related balls for the House & Ball community of black gay men. And CBC approved it. We had everything we needed. And then internally it got stopped and they said, "This is not appropriate for the health department to be doing." The community rallied around and sixty people signed onto a letter saying, "You should fund this." But we were not able to fund it.

CDC funded agencies directly. Some of our agencies have direct money from CDC and they were able to implement the programs with that direct money.

LB: So it sounds like you're constantly working around. Right?

EM: Yeah. I would say there are a lot of work-arounds. I would say the last few years I think we've had very supportive administrations. And there hasn't been as much push-back as there were in prior years—even under Governor…. I can't remember which governor it was now. I'll have to check on that. Was it Gilmore? I'll have to check.

LB: Or MacDonald?

EM: Or MacDonald, thank you. I was going, "It's not Gilmore…" Okay! Under MacDonald… he expanded HIV testing in the prisons and really insured that people who were getting released from prison had access to services. We'd been trying to get into the Department of Corrections for decades, and he really made that possible. So that was an unexpected ally that we had and something that was really helpful to us. So sometimes you don't know when or where the tide is going to turn.

LB: HIV seems like such a complex disease. Right?

EM: Mhm.

LB: In all of the people that it touches and in the intervention. Can you talk some more about more of the challenges and goals that you have?

EM: What's really interesting is—I'm in HIV prevention, so all my funding primarily comes from CDC. On the HIV care side, most of the funding comes from HRSA, the Health Resources and Services Administration. So for many, many years, everything was completely separate, and completely siloed. We did our work and they did their work. And we'd run into each other in the hall and talk about collaboration. Then when the national HIV/AIDS strategy was released, and

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they started talking more about treatment as prevention and the HIV care continuum—our roles became much more aligned. And now there's a much greater collaboration between prevention and care. We look at kind of one giant continuum of services. There's still some things that only CDC funds and still some things that only HRSA funds, but there's a lot of stuff in the middle that can be funded by either program. So that has required greater collaboration, and it's benefited prevention because prevention is funded… it's a miniscule amount compared to care and other services around HIV. So anywhere we can get a foothold or somebody can help us with paying for some services that overlap is really helpful.

It's really kind of carrying the person through from their HIV test; if they're negative what are we gonna get them? Make sure they have condoms. Make sure they know about risk reduction. If PrEP is warranted, get them on PREP. If they're positive, immediately link 'em to care and get them onto antiretrovirals immediately. And then how do we keep them in care? Do they need patient navigation? Do they need case management? Do they need housing? Mental health? Substance abuse services? Employment? So we know the social determinates of health have a big impact on people's health outcomes. So you can't just treat their HIV and expect that everything else is gonna be great.

We see a lot of people getting HIV who, at this point in time, have a lot of other things going on in their life. They have chaotic lives. They have dysfunctional families, whatever. And so a lot of times that's what contributed to their risk behaviors. Everything isn't perfect just because they're walking out of the clinic with a bottle of medication. And we're starting to look at that on the prevention side too. It's like… if somebody becomes HIV-positive, then we have this whole world of services they can access; they can get mental health; they can get substance abuse services. If you're HIV-negative, good luck. So we started doing service navigation for HIV-negative people. Now, there's not always the same funding source 'cause we can't pay for mental health services and substance abuse treatment out of prevention money. But we can at least connect people to what public services exist. We don't want somebody to have to wait to become HIV-positive before we help them improve their overall health and outcomes of their life. We have a project right now down in the tidewater area that's looking at a whole continuum of services for black, gay men and providing and getting linked to services regardless of whether they're positive or negative. It's like, "Let's serve this person holistically and not just do this one thing for them and send them on their way."

LB: I imagine that a lot of people who are at risk are also hard to reach.

EM: Yep. We don't always have venues where people are sitting around like, "We're the people at risk for HIV. Come find us." So… things have really changed. We used to do a lot of street and community outreach in the 90s and even the early 2000s, but with computers and mobile phones and all that kinda good stuff, hooking up, people do that online now or they do it through their phone. So it's not going to the park and handing out leaflets of information. And even… people don't necessarily go to shooting galleries the same way they used to inject drugs. So there's all sort of changes. People used to go and buy a drug and then they'd go into the drug house and use their drug before they left. Now people don't. They don't have to go out on the street to meet their dealer. They text them and their drugs are delivered. So even things like that have changed how we have to try to reach people.

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LB: That's completely fascinating. Can you talk more about how you meet the challenges of the digital age, whether it's Tinder and Grinder, or whether it's the dealer that you can text?

EM: Yeah! So it really requires that people know their community really well and get information from people who are on the street. We definitely have much more of a social media presence than we used to. The health department is not always the quickest on uptake for social media because our greatest priority is always confidentiality, security of our data. We have a lot of firewalls here to make sure that we can't be hacked and those kinds of things. Even putting out information on social media—the health department has taken kind of a cautious approach. But we do have a Facebook presence, and we do advertise on the dating apps. We even have a survey that people can take at home, an HIV test kit. So they get a survey link through their mobile phone or through Facebook and then we will ship them a home test kit. So that's been a great way to reach some people who are never gonna come into the health department. They're never gonna go to a community-based organization, or their doctor's office, for an HIV test. Or people in rural areas who really lack transportation to get to a clinic. So we have kind of adopted this no wrong door to testing policy. We want people to get tested as many different ways as we can think of. We want there to be an opportunity for people.

In terms of what's going on with injection drug use, of course, we've got this big uptake with the opioid epidemic, but who our drug user is has changed a lot. You used to think about middle-age to older African American men who were injection drug users, who got HIV. Now we're seeing that injector be a young, white woman, probably in her teens or twenties and that is not the typical opioid user and they're living in a rural area versus an urban area. So a lot of your old-style traditional street outreach models that were intended for the middle city don't work in a rural area. So there has to be new ways to connect to people. We're looking at the use of mobile vans to get out into the rural areas where they don't have public transportation and making sure people get access to services that way.

LB: So how do you work with kids in a state where sex education is very, very limited in the schools?

EM: Right. As far as HIV goes… and we used to do a lot more work with the Department of Education than we do now. At one point they turned back their HIV grant money so we don't have that same connection we did with them. I think that's still a hole in what's going on education-wise—that kids aren't getting comprehensive sex education and its different in every school's district. So in Northern Virginia you might have really comprehensive sex ed., they do a fantastic job. And then in other districts they may be taking an abstinence-only approach. We tend, in my program, to reach folks who are like sixteen and older. Hopefully we're getting to them early enough that we can help stop the spread of HIV. Lots of STDs in that age group. Lots of STDs in college students. We don't see as much HIV in that population which is great. The young people who are getting HIV are not necessarily the kids who are enrolled in college. Folks like to spend a lot of time on college campuses. We don't find a lot of disease on college campuses. It's the kids we can't find, because they're not on college campuses, they're not at a venue, that are really the ones that are at risk. So that's definitely a challenge. Looking at activities that bring in young people, trying to have some social engagement, especially for

young, black, gay men. Some of them—they're not old enough to go to the bars yet. And yet they need a social outlet. And you don't want them to be in a destructive social outlet so looking for opportunities where they could build community, learn how to have relationships, get educated about HIV, have fun all at the same time, provide a safe space for them to go whether they need a computer to work on a job application or whatever, so trying to create safe spaces, I think, is really important for that.

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LB: So, like a resource center or something like that?

EM: Yeah, like a resource center. In Roanoke they have a place called the Drop-in Center where people can come in. It's used as a social venue, a testing venue, and also, yeah, they have activities for folks.

LB: So one of the things that Sarah Monroe talked about a lot was men who were on the down-low giving HIV to their wives. How do you work with that?

EM: Well I think the whole down-low phenomenon was overblown. It was in the 90s, J. L. King, I don't remember his name, it was all over Oprah and everybody else and I was like, "The whole HIV epidemic is not being driven by men on the down-low giving HIV to their wives." We've actually seen a big decrease in HIV among women in the last few years. We're turning the tide there. It's definitely, sure, something that happens. Some surveys we've done in the past showed that bisexual men were actually more likely to use condoms with their male partners than gay men were with their partners. I think specifically for that reason it was like, "Oh, if I bring this home, somebody's gonna find out about what I've been doing." It certainly happens but, again, I don't think it's driving the epidemic. Now, Dr. Monroe's treating women with HIV, so she might've heard the stories from the people it has happened to, definitely. But I think we primarily still see HIV as gay men are still our greatest risk. We're also planning to prevent outbreaks among injection drug users as we see that increasing.

LB: But it sounds as though injection drug users are not accounting for a lot of new cases now.

EM: No, they're not. And even though we never have syringe exchange in Virginia, we saw our rates drop greatly along with many other states. So when I started working in HIV, drug users were probably more than 20% of our HIV cases. Now they're down to 2 or 3% of our HIV cases. But we take the lessons of what happened in Scott County, Indiana in 2015 where it was a county that had one to two cases per year among drug users and then they ended up with over 200 cases. Virginia has eight vulnerable counties, identified by CDC, that have the conditions that could lead to an outbreak. Because there's such an increase in opioid use, deaths, overdoses, and hepatitis C rates are climbing exponentially… Hepatitis C is a great marker for "HIV is next." It's more easily transmitted than HIV and we know it's already rampant through injection drug use communities, so it just takes that one person entering the network with HIV, and you've got a bunch of infections.

Although if you look at our data, you'd be like, "Why would you be spending so much time on injection drug use?" We haven't spent a huge amount of time or money on it in quite a number of years because it kept declining and kept declining. So now we're like, "Well that's keep that

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decline where it is." And it's been more now in southwest Virginia where we have huge hepatitis C cases, but we're not seeing the HIV. But we're still testing and testing and testing 'cause we wanna know if it happens. We need to be able to intervene and set up services and get a rapid response in place. It's really about… if we ignore it and then we have an epidemic among that population… we've had plenty of warning that it could happen, so we need to be prepared. So we're working on rapid response plans and we're making sure that everybody's geared up. It's like, "What if Scott County happens here? How quickly could we deploy people, resources, tests? How quickly could we set up testing?" All those types of things. So that's one of the big efforts we're working on this year is just making sure: A. we can detect an outbreak with our data and making sure we're reviewing our data all the time to identify any potential changes. And then being ready programmatically to hop on it and get out there and do the work.

LB: Now let's talk about Richmond.

EM: Mhm.

LB: Many questions come to me. Why do we have such an incredibly high HIV infection rate and STD rate? And second question—why does no one seem to know about it?

EM: I don't know why nobody knows.

LB: I mean its kind of shocking to me. Right?

EM: Yeah.

LB: Because I do lots and lots of work in the community and I hear about things and no one ever talks about our crazy HIV rate.

EM: Yeah. Well you're right. It goes right along with the STD-rate. So there's not a surprise there that they're linked. I think just in general HIV follows along with all the other social determinates of health where you've got economic challenges, education challenges, lack of access to health care; all those things contribute to HIV. I remember a study I read a few years ago that said poverty was a greater predictor of HIV than race was, that if you evened it out, if you kind of compensated for poverty—there would be pretty much equal HIV rates by race. So it really is a disease of poverty, which hardly anybody ever talks about. That's why all those things like education and housing and mental health and all those places. You know, if you're struggling every day to wonder how you're gonna keep the lights on or feed your kids…HIV is not your greatest priority. If you don't have a place to live because your mom kicked you out of the house because you're gay, then HIV is not your greatest priority. You need a place to sleep tonight. So I think just Richmond being a less wealthy place than the surrounding counties, definitely all those factors remember it as well. You asked me something else about that? And I'm not remembering the second half of my answer.

LB: Well, I mean, part of it was why is it such a secret?

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EM: Okay. Well, the stigma persists. We have made a lot of advances; nobody's calling me about getting their carpet shampooed anymore. But there's still that stigma around HIV, even within communities. I know in the transgender community we see, there's a lot of internal stigma against women who have HIV. And there's very, very high HIV rates. You'd think as high as the rates were, it would be more normalized, but yet it seems to just drive the fear even more.

LB: So why such high rates in the transgender community? And why such stigma?

EM: Well transgender people are stigmatized anyway. They have a hard time finding regular jobs. If they are transitioning or they don't appear… if their body does not match who they say they are—people don't wanna hire them. So many people turn to sex work. Many people also are injecting. They're injecting silicon, they're injecting hormones on the street because they can't find a doctor to do it, and then, you know, we have extremely high murder rate among transgender women. So, you know, they're out on the streets and they're a target for anybody looking to cause harm to people. People who are transgender in general, I think you can tell from all the bathroom controversy that's been going on the last couple of years, it's still not accepted by most people. So you have people who have led lives where they've been discriminated against by their families, by their healthcare providers. A lot of healthcare providers won't see them so they don't have access to healthcare. And you think about the psychological trauma that causes to people. And, you know, what do people do when they have trauma? They turn to things like sex and drugs and things that are gonna make them feel better. People are looking to survive and they're looking for anything that will make them feel better. I think that's true for all the stigmatized populations. We're looking at what's going on among African Americans and the racism that's so blatant right now, and the police brutality. You wonder why people are traumatized. Why would they seek out comfort and care? Part of it, I think, is self-care. "I want to feel better because my life is very traumatic and when I walk out my door, I don't know if someone's gonna shoot me." Again, HIV is not at the top of your list when you're just looking at daily survival. So I think that's why those populations, we really need to make sure, are welcomed in our clinics, that we provide culturally competent care, that our providers are trained in using the proper pronouns when speaking with people. That's a big learning curve, and it's been going on for a long time.

A lot of primary care physicians are not comfortable taking a sexual health history from their patients. They come in… You know… I saw my doctor last year and he's reading from the list of questions they have to read from the computer now. And they're like, "You're not at risk for hepatitis C, are you?" You know? He didn't ask me…. He asked me the question, but he assumed the answer was gonna be "No," and that I wouldn't say, "Oh actually, I'm at risk for hepatitis C. Here's why…" And so I think a lot of doctors always assume: "Well not my patients." Talking with doctors about…

We did a study a few years ago looking at HIV testing among pregnant women, because we know we can prevent HIV to the newborn. And women, African American women, delivering in public hospitals, were more likely to get tested for HIV than white women were seeing private physicians, 'cause the physician's attitude was—"Well she's married," or, "Well not my patients. They're nice ladies from the West End." Trying to educate all providers… Well this is actually the law; you're supposed to be testing all pregnant women for HIV. 'Cause we don't really know

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everything that goes on in people's private lives. So, and not making those assumptions and just offering those services across the board… so there's definitely more health education that needs to go on with providers. There's a lot of missed opportunities for HIV testing. When people go in for their annual wellness visits—they should be offered an HIV test. And most private providers don't do it. People do get tested if they seek it out or if they go in with a specific health condition that makes someone suspect HIV. But there's definitely ways to find those folks who still need to be tested.

LB: So how do you find Dr. Conservative Fuddy Duddy in the West End who doesn't wanna ask those questions… how do you work with those providers?

EM: So we do fund a healthcare provider education. We try to get them recruited into continuing education opportunities. We are going to start doing some public health detailing. It's also called "academic detailing," which actually will go make visits to providers' offices to talk to them about a public health problem. You say, "Hey, this is what's going on in your community." Give them local statistics and data and then you say, "And here's recommendations." And so we're trying to increase private providers prescribing PREP. Most of them have still not heard of it, the providers. I think the public has heard more than the providers. And then they're like, their response will be, "Well I'm not an infectious disease physician." Our response is, "Well these people don't have an infectious disease. This is a daily pill. Prescription is pretty easy. There's a couple tests you have to run every three months, but any health care provider can prescribe PREP. People who have insurance are looking for PrEP and can't find anybody to prescribe it for them." So that is our… In addition we're gonna be mailing information out to providers. We're doing a lot of continuing education series. But we're also gonna be sending out some nurses to go meet with the providers in their offices and talk up PREP, give 'em the guidelines, point to where the CDC recommendations are. It's a lot to keep up with. HIV is changing so rapidly. There's so many things going on with it that the average provider—it's not their specialty. They're not gonna be aware of everything that's happening.

LB: It's fascinating though that that's where the wall is. You know? The last place that someone from outside the field would think would be the wall.

EM: Right. Yeah, yeah.

LB: But you're certainly not the first person to say that.

EM: I'm sure I'm not.

LB: So say you are trying to reach populations that, again, are traumatized, have very, very difficult lives, are living in areas of the city with very low life expectancy, high unemployment… what are some of your other strategies? I live in Church Hill. I see the billboards, but…

EM: Right, right. So we still have people who do some traditional street outreach, who'll go out in the communities and talk with people. Richmond City Health Department, I know, has resource centers set up in the public housing areas where people can go get blood pressure,

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diabetes, their HIV test, really trying to insert HIV to make it more normalized so that it's like, "Oh my god, it's HIV"—well let's offer it along with all the other health services.

One of the reasons we expanded our testing program to pharmacies, it was to try to reach the people we couldn't reach any other way. We actually had a federal demonstration project. We wanted to increase testing in areas that we potentially could have HIV, where they have high poverty, high minority population, but maybe we didn't have a lot of test sites. And so we entered into a partnership with Walgreens. We're now in 31 Walgreens across the state, including several in Richmond. Actually Richmond area we have probably the most uptake of Walgreens testing of any part of the state. We get a lot of tests coming out of the Richmond area, which is great. A Walgreens customer tends to be a woman. People getting a test at Walgreens tend to be men. So for some reason, getting a test at a pharmacy is much more acceptable to them than maybe some of the other choices.

And you can get a test whenever a pharmacy is on duty. And most of that testing then happens after hours. So one of our strategies is providing services during non-traditional hours and non-traditional locations. Not everybody's gonna go to their doctor. They're not gonna go to the health department. They're not gonna go to a community-based organization that everybody knows is the AIDS agency. But if they go to a pharmacy, well you could be going for a flu shot. They don't know why you're going into the private room with the pharmacist, so it offers a level of confidentiality that I think is appealing to people.

We're really trying to increase uptake of testing through the pharmacies. It's a good, cost-effective model for us. Other places in the country have tried pharmacy testing where they're embedding a staff person. Well for us to be in 31 stores, we'd have to have at least 31 people. That's really cost-prohibitive. We're doing a fee for service model with Walgreens so if somebody comes in and gets a test we pay them by the test. We're not paying for somebody to sit around and wait for somebody to get a test. Just looking for more and more ways. As the number of people living with HIV, the number of undiagnosed people, keeps dropping which is good, it's what we want. It used to be 25%. I think it's not down to 13 or 14%. This is nationwide. But that also means you have to test more and more people to find those positives who weren't identified. So our old traditional thing… we'll just be in the clinic and wait for people to come in… you know… doesn't really cut it anymore. So it's like, "How else can we find people? How else can we be creative?"

You also talked about trauma. And trying to take a trauma-informed care approach to both prevention and care, train our case managers and our outreach workers on why these clients might react to you in a really negative way or somebody really blows up and escalates a situation. How do we de-escalate? How do we make sure that what that client may be reacting to has nothing to do with you sitting across the table? So just preparing our work force, making sure we're hiring people from within the community who can reach out to their peers and say, "This is a safe place." Public health, and government in general, doesn't have a great record with a lot of populations. There's a lot of history there. So trying to establish safety is… gotta be vital to reaching out to people who don't necessarily want to be found or reached.

LB: What would you say your most challenging population to reach is? In Richmond specifically?

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EM: In Richmond… I don't know that I can identify just one.

LB: Well you can give me lots.

EM: I would just say, yeah, um, young black gay men. That's driving the epidemic right now. And I think one of the issues… a lot of times they'll come for care, but they don't stay engaged in care. I think one of my beliefs is: "You're 19 years old. You probably haven't even started going for annual physicals yet like we do as we get older. You've probably been to the doctor a couple times in your life. It probably wasn't for something major. And now your first real encounter with the health care system, you've got a major disease, and there's lot of rules and paper work and eligibility for Ryan White funding and you have to have transportation to get to the clinic, and what if it's only open when you work an hourly job and you can't get off work to get there, and then…" You know, all those things. I think they can be very overwhelmed.

I remember talking to some young men at a meeting and I said, "So, tell me about your colleagues, bla, bla, bla, bla, bla." And one of them said, "Well I actually dropped out of care and here's why…" And he went and saw the infectious disease doc and he said, "Well, you know, the appointment was really fast and they didn't provide all this reassurance to me, and this, and this, and this." And I'm thinking, "Infectious disease doc. Really busy. She's got a hundred other clients in the waiting room." It's not that she doesn't care, but this person was looking for comfort and support from the encounter with the clinician, rather than from like a patient educator or a nurse or someone else. Because of that is why we've greatly increased the use of patient navigators, to help people from the time of diagnosis. "I'm going to go with you to the clinic, and I'll sit there with you during your first appointment. We can ask questions together. And then if you have questions after the appointment, I can help you answer them," and make sure they know to get their medication picked up, and just providing that extra security to people. That's really help [sic] because the I. D. doc just cannot provide thirty minutes of hand-holding to every patient who comes through the clinic. I think for those young people who are probably really scared, having somebody—sometimes it's a peer who also has HIV—can really help them stay engaged. I think the people who have been very successful at staying engaged in care and getting to an undetectable viral load, you know, cite, "Well so and so was so helpful to me when I got diagnosed 'cause I really relied on them." So making sure people have that initial support.

LB: How long does a patient navigator stay involved?

EM: It can depend. On average it's about six months. We have one program that's for people being released from prison called CHARLI, Comprehensive HIV AIDS Resources and Linkages for Inmates. So a lot of times people get out of prison or jail, they have HIV, they were getting treated while they were in prison and then they disappear. So we're trying to keep that connection. In our CHARLI program, we follow people for 18 months, because they're at the highest risk for A. being reincarcerated, dropping out of services. They come out, they have no housing. They need a job. It's hard to get a job when you have a record. So we follow them for

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18 months because we really wanna make sure they're on firm footing and they're staying in care. We make sure they have a prescription before they leave prison so that they're not immediately running out. And we make sure they have an appointment with a care site before they leave. 'Cause what used to happen is they would get 30 days of meds from the Department of Corrections and they would call us on Day 29 going, "I'm out of my HIV meds." And then you've got a crisis because—can you get them into care in a day? They've got to be illegible, so… CHARLI is also doing some short-term housing for people to help them get on their feet and have a place to live and get some household goods assembled and help them look for a job and all those pieces. We've had great success with the graduates of that program. Then they can go on to regular case management and still stay engaged in services. But we really try to do really intensive services with that program.

LB: So what policies, either federal, state, or local, would you most like to see change regarding HIV?

EM: Personally…

LB: Yeah.

EM: I would like to see CDC loosen up a little around use of federal dollars for PREP. CDC is really pushing the biomedical interventions, of which that is one, but they won't pay for them. And it's prevention. It's not care. I cannot use federal Ryan White dollars to pay for PrEP because that's only for people living with HIV and these clients don't have HIV. I understand we can't use federal prevention money to pay for the meds. They're very expensive. It would eat up the entire budget. But things like a clinician visit, or the lab costs. I can pay for the HIV testing and the STD testing. But I can't pay for the creatinine clearance test, which is a kidney function test needed every three months when you're on PREP. So CDC will allow us to pay for counseling, patient navigation for PREP, all those health-education-y pieces… risk assessment… following up with the client… do they need to come back in?... but they won't pay for the clinical part. We got a new five-year funding cycle that started this January and I thought they were going to allow us to do that. And so that means if somebody doesn't have insurance—who's gonna pay for their clinical visit? We can get them… you know… there's pharmaceutical assistance programs that will pay for their medication. But you have to have a prescription. You can't get a prescription unless you have a medical visit. So that's been… We use state funding to try to make up some of that gap and make sure that uninsured people have access to PREP. I'm hoping with Medicaid expansion in Virginia, that that's gonna open the door for a lot more people to get on PREP, 'cause that is covered by Medicaid.

LB: Are there other drugs that are not? 'Cause it sounds as though you're not just talking about one pill. You're talking about a range of kind of supporting medications that you need to…

EM: So mostly it's the PrEP drug, but we also do nPEP which is non-occupational post-exposure prophylaxis. So if somebody's been sexually assaulted, or the condom broke, or "I found out two days later the person I was with was HIV positive." You can take HIV meds for 30 days and it will stop HIV from taking hold in your body. You have to start PEP or nPEP within three days of exposure. So if it happens on a Friday night and it's Monday morning and

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you don't have insurance, bla, bla, bla, bla, blah... A lot of times people go to the E.R., and the E.R. says, "Well yeah, I can give you the prescription if the person can't get it filled." A lot of E.R.'s don't even know about PEP. They even know less about PEP than they do about PrEP. Some of the hospitals have great sexual assault programs with sexual assault nurse examiners who do a lot of that programming. They're all up on it. So if you end up at the right hospital in the right location… I know Bon Secours in Richmond does a great job at that. But if you're out in some county and they've never heard of any of those things, you're not gonna get your meds.

So it's the same thing for nPEP. We can't use our federal funds to pay for the meds or for the clinical visits. So we're trying to run both PrEP and nPEP through our STD clinics, because we already have clinicians that are working there, and we can get drugs from central pharmacy shipped overnight. But that's not always ideal for people because, again, if you work an hourly job, you don't have sick leave, if you take off three hours to go down to the STD clinic, and wait, and get served, you know, you're losing money out of your pocket. People can't do that. So we're looking at how we can have people do medication pick-ups. We'd like to make them available so they could pick it up through a regular pharmacy, because the health department is gonna be open during regular business hours, whereas a pharmacy would be open night and weekends. So every time we kind of solve one problem we go, "Oh, now we have to adjust this access barrier." Then we'll be doing some mail order as well with people's PrEP drugs because it's hard for them to come. Every month you have to come pick up your drugs, every month. And so if you have to take a bus, you have to leave your job—those are all really big challenges.

LB: So you are mailing more drugs now?

EM: We are doing mail order for PrEP, yep. But not everybody wants their stuff mailed to their house, because if you're a college student, you don't want your mom to see. "Why do you have a box coming from…? What is this?" You know. Everybody doesn't want your meds to go to your house. So some people mail order, works great for them. Some people would rather pick it up. And then I think some people would benefit if we had some afterhours pharmacy. We're working on all of it.

LB: It sounds like it. If you could say one thing to the general public about HIV, what would it be?

EM: I would say, "Please get an HIV test. If you haven't had one." There's many different places and ways to get tested. We have anything from a one-minute test, to a lab-based test. And I think I would also say, "Don't be afraid." People with HIV are living nearly normal life spans now, thirty years or more, so… but if you don't get tested and you don't get on medication… we can't help. So that test is the first, crucial step. Everything else stems from that. I think many people don't get tested because they are afraid. I just had a friend… I've been on Facebook with him for years, I've known him since the 90s. And he just recently sent me a private message and said, "I've had HIV for years and I haven't told anybody yet. I just wanted to thank you for the work you're doing." I was like… you know… I texted and messaged him a lot, but even now, in 2018, there's somebody who's known since 2010 that hasn't told their family, hasn't told anybody, and they're terrified. That's not unusual. And until more people start normalizing… There's a lot more people living with HIV around you than you'd think. Get the test. Know that

you can live a long and healthy life. Know that you can live with this as a chronic disease as long as you take care of yourself.

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LB: Are there any questions that I didn't ask you that you would like to address? Anything that you're thinking about. I know one question I didn't ask.

EM: Okay.

LB: What changes have you seen in the way the general public views HIV and AIDS? Has the public emotion or perception caught up to the medical reality?

EM: It hasn't caught up, but it has definitely progressed. I personally… when I first started working in HIV and I'd be at a party and somebody asked me what I did and I just said I worked on the hotline—they would physically take a step back from me and be freaked out. I'm like, "I'm not even working with patients. I'm answering the phone." So that was like 1987. And now I think when people ask me what I do and I tell them, they say, "Oh my god! That must be really fascinating. That sounds like a really interesting job." So I think just from a personal perspective that people are more likely to lean in than go, "Oh," and lean back and go, "Oh my gosh." But I think there's still a lot of stigma out there. There's still a lot of fear. I don't… It's not as bad as it was, but it lingers. It remains. So… And I think it's tied into everything else that's going on with racism and homophobia and the anti-transgender movement that seems to have come along. You just layer HIV on top of that. I heard said one time that "HIV didn't create any new problems in society—it just put a magnifying glass on all the problems that were already there." It's just a layer over what was already a problem. And I think that's really true. I've seen that bare out over the years.

LB: Now that's so well put. Thank you so much.

EM: Sure.

LB: What a great interview.

EM: Thanks! I guess one thing I will add is that I've been working… 31 years I've been here working in HIV—I think now is the most exciting time. Yes, it is possible. We could see a real end to HIV. We saw a dip in cases in the past year and I'm like, "Is that a real dip? Is that a statistically significant dip?" I'm waiting for Treatment is Prevention and PrEP to show up in our declining numbers and I think that it's really gonna hit in 2018 that we have enough people getting PrEP and we have enough people in care that we are gonna see the tide turning. Despite the many years I've been here… Ahh I must be really bored and disillusioned with it all—but no! It's still exciting, and it's still a worthy cause. There's still people in need. It's still where I feel my dedication is.

LB: Thank you! That was a great interview.

EM: Thanks.

00:55:48 **LB:** As you were talking, I kept thinking of quotes that I wanted to excerpt.

EM: 31 years I have a lot to say, so.

LB: Yeah you do. And think if there's anyone else you know that I should interview, especially people of color.

EM: Okay. You looking for clients? Or are you looking for…

LB: Clients too. The only HIV positive person I have so far is Rodney Lofton over at Diversity, and he's great.

EM: Oh yeah. Okay. I can definitely contact some people and see if they would be interested. And then the other person… I don't know if you want another health department person or not, but Marquietta Alston who works on my staff, she's been working with the faith community for about 20 years.

LB: Yes.

EM: And so she's got great insight into the impact of the black church on HIV and vice versa. She's done a lot of work around that. She's been here since '92.

LB: That would be fantastic.

EM: And so she has sort of a long-term perspective. Let me check in with her.

LB: Please do. That would be great.

EM: And I have an employee who's living with HIV. He's a white man, but he's very interesting because he's only been infected for a few years. And he can talk about how he just missed PrEP. He would've been the ideal candidate for PrEP. And why he's so passionate about people getting on PrEP because it was like a year before PrEP that he got infected. So most people I know with HIV have been living with it for decades. He's one of the people I know who's been more recently diagnosed. And he moved to Richmond from Philadelphia.

LB: Did he contract HIV here or there?

EM: No, he actually contracted it there. But I certainly do know other Richmonders. But anyway he might be interesting to talk to as well.

LB: That would be great.

EM: Okay.

LB: And then the other category of people who I really wanna hit are young people with HIV. Ariel is gonna be in the class this fall where we're creating booklets with portraits and text

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panels from the interviews and we're also writing a documentary drama that we're going to present.

EM: Okay. I know more people statewide than I even do specifically in Richmond just because my job is more statewide. But I can definitely talk to some people. We could probably identify some folks for you and ask them if they're interested and then share the information.

LB: That would be really wonderful. Thank you.

EM: Sure.

LB: Yeah. I mean I feel like I keep learning a lot with every new interview.

EM: Well I did… like two years ago VCU was doing… they asked me to do a talk on the history of HIV in Virginia. So I spent a lot of time pulling old documents up—stuff I hadn't looked at in like twenty-something years and I kept going, "Forgot about that! Forgot about that happening. Forgot about that happening." And it was like, "Oh!" It was really… I do it every year now for new employees coming in because I realized the young people—they weren't around when people were wasting away and their bodies were covered in scabs and Kaposi's sarcoma. They didn't see the early days. So the impact to them is much, much different. And knowing the historical pattern of what happened, I think, really helps them to have context for what's going on now so that kind of brought up a lot of this to me that… I just sort of forgot about the bad old days and how bad the bad old days were.

LB: Yeah.

EM: It's like 'cause we always have a problem. We're always trying to deal with the problems. But sometimes we forget that, "Oh, we've had all these great victories." And sometimes we don't think about that.

LB: Are those documents accessible to the public?

EM: I can send you my PowerPoint if you'd like.

LB: Yes.

EM: It's kind of funny 'cause it's kind of got the timeline and it says… I kinda did it by decade. Like this is kinda what was going on in the 80s data-wise, what we were doing, you know, what were the big achievements and advancements and then what was the social-political impact of what was going on there. You know, one time it was abstinence education. This and that and the other stuff. Rock Hudson making his announcement had a huge impact.

LB: Magic Johnson.

EM: Magic Johnson. Our hotline…. Like we used to get 20 calls. We were getting like thousands of calls. I mean stuff like that. We were on Channel 12 answering questions. And

some of those early things. And so it's going through the 80s, the 90s, the 2000s, and what's going on now. And I think the data in it is like a year old for the current data. But I'm happy to send that to you. You can certainly look at it.

LB: Thank you. That would be great. Because you know when we create dramas, they're always based on documentary sources, interviews, and you know whatever we find in the archives as well as what's online.

EM: Sure, sure.

LB: That would be super helpful.

EM: Sure. Will do.

LB: That's wonderful. You do have an exciting job.

EM: It is. Sometimes it makes me crazy, but it's exciting most of the time. Thought it was an easy job. But it's always an exciting job. Never bored.

LB: That's the best kind of job to have.

EM: Right? Absolutely.

Ariel: There's so many pieces. I'm so sorry.

LB: I know. We're always struggling with the equipment.

EM: I'm sure.

LB: But good. Yeah, so please. If Marquetta is that it?

EM: Marquietta.

LB: Marquietta. If she's interested, that would be a fantastic addition.

EM: Okay. Yeah. I will put a bug in her ear. And I'll think… I know there's people I could think of, they're just not coming to the top of my head, so let me see who else I can come up with who might give you a good perspective. I wish Ryan was still here. Bless his heart. So our hotline supervisor for twenty years was Rylan Roan [01:01:33 unc. name spelling]. He passed away in 2015 of leukemia, but he was living with HIV since the late 70s… 80s, sorry. He always had great stories. And he's from Richmond. He was a lifelong Richmonder. He would've been so ideal for you to interview. We lost him in like a week. We had no idea. He was at work and then he was dead. I mean it was like that. So we're still, three years later, going, "Oh my god, what happened?" You know, with Rylan. But he would've been so great for this interview because he had such great perspective on the African American…

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