

**Title:** Addressing Barriers to HIV Care and Prevention Services Following Release from Incarceration for People with and at Risk for HIV

**Authors:** Castillo A<sup>1</sup>, Rojas Antigua J<sup>2</sup>, Smith D<sup>2</sup>, Kaba-Diakité F<sup>2</sup>, Ko Sweet V<sup>1</sup>, Mulcahy L<sup>1</sup>, Linder M<sup>1</sup>, Riback LR<sup>2</sup>, Ross J<sup>2</sup>, Fox AD<sup>2</sup>, Akiyama MJ<sup>2</sup>

<sup>1</sup> The Fortune Society, Long Island City, NY

<sup>2</sup> Albert Einstein College of Medicine, Montefiore Medical Center, Bronx, NY

**Background:** People with criminal legal system involvement (PCLSI) experience higher HIV prevalence than those without such involvement, yet access to HIV prevention and treatment remains sub-optimal. In designing a decentralized, status neutral, stakeholder-engaged, post-incarceration intervention, we aimed to identify key barriers to HIV-related care for PCLSI from the perspectives of community members and staff at a reentry-focused community-based organization.

**Methods:** Qualitative data were collected from Community Advisory Board (CAB) meetings with people living with or at risk for HIV with histories of incarceration, and stakeholder meetings with staff from The Fortune Society. Meeting agendas were co-designed and co-facilitated using community-based participatory research principles to reflect participant priorities and experiences. Audio recordings were analyzed in a modified rapid qualitative analysis approach using structured summary templates to extract illustrative quotes and record implications for intervention design. Analysis was conducted collaboratively through iterative discussions to refine codes and confirm interpretations.

**Results:** Data from seven CAB meetings (n=10) and two stakeholder meetings (n=26) revealed multi-level barriers to HIV care following incarceration. Participants described systemic instability, including disruptions to housing, employment, and insurance, as major barriers to engagement. Staff highlighted organizational constraints, including workforce shortages and funding limitations, that restricted their ability to meet participant needs. Both groups emphasized that structural barriers are often framed as individual failings, contributing to bidirectional mistrust between patients and providers. Peer navigation emerged as a critical strategy to bridge fragmented systems and support sustained engagement in care through accompaniment, nonjudgmental support, and facilitating communication between patients and providers.

**Conclusion:** PCLSI and stakeholders identified peer navigation as a promising strategy to address multi-level barriers to HIV care. These findings informed the development of the Community Health Advocate (CHA) model, which centers empathy, confidentiality, and sustained relational accountability to improve continuity of care and rebuild trust following incarceration.

**Disclosure of Interest Statement:** MJA reports grants from the National Institute on Drug Abuse (DP2DA053730, R00DA043011, R61/R33DA060627), National Institute on Minority Health and Health Disparities (R01MD016744), National Institutes of Allergy and Infectious Diseases Centers for AIDS Research (P30AI124414), and investigator-initiated research funding paid to his institution from Gilead Sciences and AbbVie. ADF

reports grants from the National Institute on Drug Abuse (K24DA057873, R61DA059032, UG1DA013035) and royalties from Wolter Kluwer for authoring an online chapter on UpToDate. JR reports grants from NIMH (R21 MH137757) and NIDA (R34 DA065464) and consulting fees from Prime Continuing Medical Education.