

Mississippi's Ending the HIV Epidemic Plan

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MISSISSIPPI STATE DEPARTMENT OF HEALTH

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Executive Summary

In January 2019, the White House announced Ending the HIV Epidemic: A Plan for America (EHE). The plan focuses on 57 jurisdictions – 50 counties and 7 states with the highest rates of HIV, including Mississippi as one of those states. The plan sets ambitious goals – achieving a 75% decrease in new HIV infections by 2025 and seeing at least a 90% reduction in 2030.

The first phase of the federal EHE plan involves jurisdictions creating and submitting plans for Ending the HIV Epidemic in their communities. In October 2019, the Centers for Disease Control and Prevention (CDC) awarded start-up funds to the 57 Phase 1 jurisdictions to accelerate state and local planning to end the HIV epidemic. Mississippi was awarded \$390,981. In July 2020 CDC awarded Mississippi \$2.08 million through the “Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States (PS20-2010).” This funding will allow Mississippi to implement many priorities detailed in the activities section of this document, hire critical staff positions to meet the goals of EHE in Mississippi, and continue to engage with Mississippians, particularly key populations in the planning, development, and implementation of activities.

The federal EHE plan uses four key strategies that, when fully implemented and integrated can End the Epidemic in the United States (U.S.) and MS.

The four strategies are:

- Diagnose all people with HIV as early as possible
- Treat people with HIV rapidly and effectively to reach sustained viral suppression
- Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs)
- Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them

While these strategies are critical to addressing HIV in Mississippi, the community raised barriers and challenges to Ending the Epidemic in MS that didn’t fit neatly into those four strategies or warranted a different framework for inclusion in the Mississippi plan. Therefore, Mississippi’s plan also includes four additional strategies that will allow the state to implement justice-oriented, whole-health foundational activities.

The four additional strategies are:

- Increase access to effective and comprehensive care across the state
- Decrease stigma and provide life-affirming messaging and care
- Identify, address, and reduce health disparities
- Increase MSDH capacity to develop new, innovative partnerships that are responsive to the needs of the individuals most at risk for acquiring HIV in MS

The Mississippi Ending the HIV Epidemic Plan (referred to in this document as the EtHE Plan) builds upon the state’s Integrated HIV Prevention and Care Plan for 2017 – 2021, submitted in

September of 2016. The EtHE plan aims to further integrate HIV prevention and care services alongside strengthening services aimed at addressing social determinants of health including substance use and behavioral health services, housing, and food insecurity, among others. And the plan recognizes and seeks to build upon the high-quality care offered through Mississippi's network of Ryan White funded providers and Federally Qualified Health Centers (FQHCs).

Overview of EtHE Development

The Mississippi State Department of Health (MSDH) has employed multiple subcontractors to work on this plan, with Black AIDS Institute leading the community engagement portion with the assistance of the MHPC and the MS EtHE/ETE Task Force. The MSDH engaged with several national organizations to assist in ensuring widespread outreach was conducted and all relevant notes were included for developing the EtHE Plan. MSDH contracted with the Black AIDS Institute (BAI) to lead engagement efforts and the National Coalition of STD Directors (NCS D) to assist and ensure that issues regarding STIs, and Disease Intervention Specialists (DIS) were captured and included in the EtHE Plan. AIDS United (AU) was hired as a consultant on the project to assist in ensuring all messages and feedback heard via the various community engagement activities were captured in the final Mississippi EtHE Plan. The University of Washington, has worked with the MSDH for many years on surveillance and epidemiology issues, was engaged to develop the metrics and epidemiological profile included in the MS EtHE Plan.

MSDH Ending the HIV Epidemic Contractors

The Black AIDS Institute: Founded in 1999, BAI is a leader in ending HIV in Black America by using Black leaders and communities across the country to provide capacity building, mobilization, policy & advocacy work.



National Coalition of STD Directors: NCS D is a public health membership organization representing health department STD directors, their support staff, and community-based partners across 50 states, 7 large cities and 5 US territories.



AIDS United: AIDS United is a grant-making and policy and advocacy focused organization supporting community-driven responses to the HIV epidemic around the nation.



University of Washington: UW is one of the largest institutions of higher education on the West Coast (>45,000 students) and is recognized for the excellence of its academic programs, research contributions, and public service. University of Washington, has worked with the MSDH for many years on surveillance and epidemiology issues, was engaged to develop the metrics and epidemiological profile included in the MS EtHE Plan.



The scope of work laid out for the four organizations are as follows.

AIDS United (AU): Met with MSDH representatives to formalize and finalize the plan and process for creation of the jurisdictional plan for Ending the Epidemic (the initiative); work with MSDH to develop and execute a detailed process and plan for project start up and launch, with corresponding workplan and timeline; provide MSDH with invoicing and payment schedules; provided MSDH with detailed summary of reporting requirements as needed under this initiative; designated key staff member to serve as AU lead for this initiative; designated key local representative (AU staff or designated consultant) to serve as ground-level liaison and local resources throughout the duration of this initiative; work with MSDH to plan and coordinate routine communication mechanisms among all collaborators and partners under this initiative; led the design and execution of the jurisdictional plan development strategy, including project workplan and timeline to support successful launch and implementation; led the planning, coordination and logistical activities related to this initiative, and attended community stakeholder groups meetings in representative geographic areas; final determination of geographic areas that were covered were made in collaboration with MSDH. These convenings will serve as information gathering and sharing opportunities to better inform Mississippians most at risk needs, concerns, priorities, and actions required for plan development; worked with MSDH and local organizations in the further design and adaptation of structure and core components of the plan; delivered, per agreed upon schedule, the draft and final versions of the jurisdictional plan for review, feedback, and finalization.

Black AIDS Institute (BAI): Conducted Community Engagement Sessions, of which each community engagement session consisted of three components: 1. HIV services (HIV prevention, treatment, and care) 2. Social determinants of health 3. Community needs, advocacy, and mobilization.

National Coalition of Sexually Transmitted Diseases Directors (NCSD): Participated in planning council, and other, meetings around Ending the HIV Epidemic, recorded recommendations, and used those to inform plan development; developed and wrote the MS Ending the HIV Epidemic Plan; provided unique STD perspective to ensure that STDs are represented in creative ways within the plan; identified best practices from other jurisdictions and shared/use in Mississippi's plan development; provided STD clinic specific support and shared data collected via our STD clinic survey; in partnership with our national partners help identify additional community partners for engagement in the development of the EtHE plan; and will use the soon to be launched coalition toolkit to support the health department in identifying and convening a committee or council to support the planning of activities in response to need.

University of Washington (U of W): Developed HIV/AIDS epidemiologic profile for Mississippi State Department of Health (MSDH), Developed a dashboard to track progress toward EtHE goals, wrote a summary of new data collection activities to include in the final EtHE plan, developed the final HIV/AIDS Epidemiology Report, hosted regular Zoom videoconference meetings with MSDH team, and conducted In-person meetings as needed.

Over the past year, the contractors and the MSDH have met regularly to develop the plan. An engagement plan was developed to expand opportunities for the community to provide their experiences and to influence the MS EtHE Plan. In 2019 and 2020, over 7 events were held to engage communities and discuss specific strategies and communities. Plans to engage the community were altered and delayed due to COVID-19 and its subsequent staff deployments and shifting or priorities. However, the MS Ending the HIV Epidemic/The Epidemic Task Force was developed to ensure that effective community engagement was conducted among target populations most at risk for acquiring HIV/AIDS in MS on an ongoing basis.

The MS EtHE Plan is an ambitious plan and acknowledges the challenges seen in Mississippi and the strengths identified through sessions with impacted populations. Over the past several years, Mississippi has worked with federal partners, health clinics, Community-Based Organizations, and community members to build its foundation to provide high-quality HIV prevention and care services throughout the state. The EtHE Plan is a culmination of that work and an acknowledgement of the intense work needed to End the HIV Epidemic in Mississippi.

Priority Populations

In consultation with the state's planning bodies and led by the data, several populations were indicated as priority for EtHE. The MSDH has committed that resources will be dedicated to supporting locally- and community-led planning for each of these populations and developing programming specific to these populations. The priority populations for the EtHE plan include Same Gender Loving Black and Latino Men, Black Women, Transgender, and Gender Non-Conforming (TGNC) individuals, and Latinx individuals, and anyone having sex. The plan's activities speak to these populations specifically and consider the specific needs of these priority populations during the development and implementation phases.

In Mississippi, the burden of HIV is disproportionately high for Men of Color who have Sex with Men (MSM). Among men whose risk factor for HIV is known, 84 percent of men reported having male-to-male sexual contact. Young adults aged 20-29 are the leading age group for newly diagnosed cases. Older people in Mississippi are more likely than younger people to have late-stage HIV infection at the time of diagnosis. People aged 50 and older may start treatment late, which may put this population at risk of more immune system damage. Therefore, increasing the number of individuals who receive Rapid ART is a priority of the MS EtHE Plan and activities.

Community Engagement

Central to the EtHE Plan is engagement with individuals most at risk for acquiring HIV across the state about the barriers and opportunities to End the HIV Epidemic in MS. HHS describes EHE as a whole-of-society initiative: "in addition to the coordination across federal agencies, the success of this initiative will also depend on dedicated partners working at all sectors of society, including people with HIV (PWH) or at risk for acquiring HIV; local, tribal, and state health departments and other agencies; local clinics and healthcare facilities; healthcare providers; providers of medication-assisted treatment for opioid use disorder; professional associations;

advocates; community- and faith-based organizations; and academic and research institutions, among others.”¹

The Mississippi HIV Planning Council

Mississippi developed several avenues to meaningfully engage with individuals and groups about HIV and the EtHE Plan in Mississippi. The Mississippi HIV Planning Council (MHPC) is a long-standing planning body and has assisted the MSDH to develop the Integrated Prevention and Care plan as required by CDC and the Health Resources and Services Administration (HRSA). The MHPC regularly assesses the extent and impact of HIV on Mississippi's population and determines the needs for HIV prevention and treatment-related services. It ensures that HIV prevention and care resources target priority populations and are congruous with interventions outlined in the comprehensive plan. Membership of the MHPC consists of representatives from state and local agencies, Community-Based Organizations (CBO), health care providers, community leaders, and individuals with, or affected by HIV/AIDS. Additionally, the Council may advise MSDH about urgent issues as they arise.

The Mississippi Ending the HIV Epidemic Task Force

The MSDH acknowledged that the current planning structure was insufficient to meet the requirements and goals of the EtHE planning process. To better engage a broader audience and new voices to inform this process and initiative activities, the MSDH established the MS Ending the HIV Epidemic/The Epidemic Task Force in the spring of 2020. The Task Force regularly assesses the extent and impact of HIV on Mississippi's population and determines the needs for HIV prevention and treatment-related services for this and other HIV/AIDS related initiatives within MSDH. It ensures that effective community engagement is conducted among target populations most at risk for acquiring HIV/AIDS in MS. It also ensures that HIV prevention and care resources target priority populations and are responsive to the needs of the individuals most at risk for acquiring HIV/AIDS in MS. Membership consists of representatives from state and local health and social services agencies, community-based organizations, health care providers, community leaders, and members of various vulnerable populations most at risk for acquiring HIV and include individuals with or affected by HIV/AIDS. The Task Force will also advise MSDH about urgent issues as they arise.

The MS EtHE Task Force leadership decided that working groups needed to be implemented as an integral part of the Task Force to fully engage and be responsive to the needs of priority populations and implementers of the MS EtHE Initiative moving forward. Task Force members recruited new members and will continue to recruit new members ongoing statewide to assist in efforts to assess need, identify/eliminate barriers, gaps in service, and ensure that all MS EtHE activities are responsive to the needs of individuals most at risk for acquiring STD/HIV/AIDS in MS. Leadership Collaborative Work Groups will continue to develop and conduct community listening sessions/town halls with target populations and ensure that all program

¹ About Ending the HIV Epidemic: A Plan for America, Overview, HIV.gov webpage, <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview>, updated July 2, 2020.

activities employed are evidence-based and responsive to the needs of vulnerable populations most at risk for acquiring HIV in MS.

All collaboratives were developed to ensure that all ETHE/ETE activities and awards are informed by and for groups most at risk for acquiring STD/HIV in MS. The work groups will work to develop policies, practices and actions that will affirm the holistic health care and well-being of Mississippians focused on their priority population. Learning Collaboratives will meet monthly and quarterly Town Halls to hear for impacted communities. The MS EtHE Task Force Leadership Collaborative Work Groups include:

- *PWH/Advocates for PWH Leadership Collaborative* - to provide a safe and supportive environment statewide for PWH and advocates that support PWH to develop and implement activities that are responsive to the needs of PWH and their communities.
- *Black Same Gender Loving Men Leadership Collaborative* - to provide a safe and supportive environment statewide for Black Same Gender Loving Men to develop, implement activities that are responsive to the needs of Black same gender loving men who are at higher at risk for acquiring HIV and other STDs in Mississippi.
- *Black Women Leadership Collaborative* - to provide a safe and supportive environment statewide for Mississippians that are Black Women to develop, implement and sustain MS ETHE/ETE activities that are responsive to the needs of Black women who are at higher risk for acquiring HIV and other STDs in Mississippi.
- *LGBQIA Leadership Collaborative* - to provide a safe and supportive environment statewide for Mississippians that are LGBQIA to develop and implement activities that are responsive to the needs of LGBQIA.
- *Latinx Leadership Collaborative* - to provide a safe and supportive environment statewide for Latinx Mississippians to develop and implement activities that are responsive to the needs of Latinx Mississippians.
- *Black Transgender and Gender Non-Conformant Leadership Collaborative* - to provide a safe and supportive environment statewide for Black transgender and gender non-conforming Mississippians to develop and implement activities that are responsive to the needs of Black Transgender and Gender Non-Conforming Mississippians who are at higher risk for acquiring HIV and other STDs in Mississippi. *Transgender and Gender Non-Conformant Leadership Collaborative* - to provide a safe and supportive environment statewide for transgender and gender non-conforming Mississippians statewide to develop and implement activities that are responsive to the needs of Transgender and Gender Non-Conforming individuals who are at higher risk for acquiring HIV and other STDs in Mississippi.
- *Men and Women of Color Leadership Collaborative* - to provide a safe and supportive environment statewide for Mississippians that are LGBQIA to develop, implement activities and actions that are responsive to the needs of LGBQIA who are at higher risk for acquiring HIV and other STDs in Mississippi.
- *Community of Faith Leadership Collaborative* - to provide a safe and supportive environment/network statewide for Communities of Faith in Mississippi to develop, implement, and sustain MS ETHE/ETE activities that are responsive to the needs of

individuals most at risk for acquiring HIV and other STDs who are members of various communities of faith.

- *Survival Worker Leadership Collaborative* - to provide a safe and supportive environment/network statewide for Survival Workers to develop and implement activities that are responsive to the needs of Mississippians that are survival workers who are at higher risk of acquiring HIV and other STDs. This work group will work to develop policies, practices and actions that will affirm the holistic health care and well-being of Mississippians that are Survival Workers.
- *Transitional Support Leadership Collaborative* to address and eliminate laws and practices that criminalize PWH and to provide a safe and supportive environment for individuals transitioning out of incarceration/imprisonment back into society to develop.
- *Determinants of Health Leadership Collaborative* - to provide an environment to identify social determinants of health most impacting people at risk of acquiring HIV and PWH and identify innovative programming and best practices that can be scaled-up around the state.

Leadership Collaboratives will expand efforts to include expanded Strengths, Weaknesses, Opportunities, and Threats (SWOT) analyses for respective target population to measure the effectiveness of planned activities. Each respective leadership collaborative will work to:

- Empower targeted community members to dismantle practices, systems, and institutions that endanger the health and well-being of Mississippians who are most at risk for acquiring STD/HIV and undermine an effective, equitable response to HIV in Mississippi.
- Ensure that Mississippians most at risk are provided with resources and services that address their fullness, richness, potential, and expertise.
- Mitigate social and structural factors that worsen health outcomes in Mississippi for individuals most at risk.
- Empower individuals most at risk to work together with MSDH to ensure universal access to and robust utilization of high quality, comprehensive, affordable, and culturally- and gender- affirming healthcare to enable Mississippians most at risk to live healthy lives in full dignity.
- Advocate for capacity building opportunities to improve the quality of life and services residents most at risk receive.
- Advocate for greater flexibility for Mississippians who are most at risk to design and direct MS ETHE/ETE approaches that best meet their needs.
- Advocate for ongoing inclusion of new, diverse partners in MS ETHE/ETE planning activities.
- Ensure that the MS ETHE/ETE activities place a greater emphasis on supporting bold, innovative efforts that overcome barriers to HIV prevention, testing, and treatment.
- Ensure that the MS ETHE/ETE activities build upon community experience to develop positive outcomes and sustainable results for the MS ETHE/ETE Initiative.
- Ensure that all ETHE/ETE activities are responsive to individuals most at risk for acquiring HIV/AIDS needs and requests.

Both the MHPC and the MS EtHE/ETE Task Force serve as advisory groups in the development and finalization of the MS EtHE Jurisdictional Plan, Epi Profile, and the MS EtHE/ETE activities and review each annually to propose amendments that are responsive to individuals most at risk needs. They will also be engaged in the implementation of all activities in the plan and will be asked regularly to provide input on the development of new programs to meet the goals of the EHE/ETE in Mississippi. Membership rosters for both planning bodies can be found in Appendix B and C. Through the Task Force process many new groups were brought into the planning process. New groups involved include:

- Black Treatment Advocates Network (BTAN) MS - ensure the EtHE plan is informed by people living with HIV, at risk for acquiring HIV
- MS AETC - capacity builder, technical assistance provider
- ACLU MS - community engagement and legal expertise
- Black AIDS Institute “Blacker the Plan - partner for statewide virtual EHE Town Halls
- Transgender and Gender Non-Conforming Education and Advocacy Project (TEAP) MS - Ensure EtHE Plan is Informed by Transgender and gender non-conforming Mississippians and Responsive to Their Needs throughout the state of MS
- Mississippi Center for Justice - support EtHE efforts to educate, empower various vulnerable populations and work to ensure that HIV decriminalization is a priority in MS and that all legislative policy needs are met
- Mississippians United to End Homelessness (MUTEH) - ensure EtHE Plan is informed by Mississippians that are at risk for Becoming homeless/Homeless
- Jackson Revival Center Church - community of faith champion; ensure expanded education and services in communities of faith throughout MS
- Working Together MS
- Immigrant Alliance for Justice and Equity - Ensure EtHE Plan is informed by Mississippians who are immigrants
- MS Immigration Coalition - Ensure the EtHE Plan is informed by Mississippians who are immigrants or of Latinx descent
- MSDH Office of Preventive Health and Health Equity - provides additional support to ensure efforts are equitable, diverse, and responsive to community need
- Community Health Centers Association of MS - development/coordination of MS EHE Statewide HIV Cluster Detection and Response Team/Plan
- Community Health Workers Network of MS - expanded workforce development throughout MS to increase the number of workers from priority populations to assist in efforts to eliminate stigma associated with HIV and diversity to expand access to culturally and linguistically appropriate, affirming healthcare services
- City of Jackson, MS Mayor’s Health Task Force
- Jackson-UCSF (HRSA) Planning Group - capacity builder, technical assistance
- Gilead Science - uptake on PrEP/PEP Education/ Support
- MS in Action - focus on women of color, primarily Black women)
- MS Faith in Action – focus on communities of faith

- LIFE, Inc. – focus on LGBTQIA+ persons
- CH-PIER, Inc. – focus on men and women of Color and people living with HIV
- FABRIC, Inc. - focus on men and women of Color and people living with HIV
- Plan A Health, Inc. - Mobile Statewide One-Stop Shop Clinic
- 1 Vision Solutions, LLC. – focus on men and women of color, primarily Black MSM)
- LOVEMEUNLIMITED4LIFE, Inc. - Black Transgender and Gender Non-Conforming Mississippians
- Immigrant Alliance for Justice and Equity IAJE-FB - Latinx Mississippians
- NASTAD - capacity builder, technical assistance provider
- Institute for the Advancement of Minority Health - works to increase access accountability to Individuals Most at Risk
- MS Decriminalization Network – works to educate and empower community members and lawmakers about the importance of HIV De-Criminalization
- Mallory Community Health Center – increase access, coverage in rural and hard to reach areas of the state.
- Jefferson Comprehensive Health Center– increase access, coverage in rural and hard to reach areas of the state.
- Jackson-Hinds Comprehensive Health Center– increase access, coverage in rural and hard to reach areas of the state.
- Five Horizons, Inc. – increase access, coverage in rural and hard to reach areas of the state.
- Outreach Health Services, Inc. – increase access, coverage in rural and hard to reach areas of the state.
- JMW Consulting- contractor for statewide Community Engagement efforts

Summary of Community Engagement Sessions and Lessons Learned

Mississippi's community engagement partners, BAI and NCSO, used similar methods to engage communities throughout the state. Significant efforts were made by BAI to engage with the people in Mississippi to better understand challenges, needs, and beliefs about how HIV and STI prevention, care, and treatment services are being delivered in the state. Plans for community engagement events included in-person interviews, focus groups, and community town halls in each region. However, the development of the COVID-19 epidemic made traveling and holding in-person events unsafe. The teams quickly pivoted to a remote process, ensuring involvement of priority populations. For more detailed reports from the community engagement events please see Appendix C.

Listening/Work Sessions and Town Halls

EVENT	DATE
MS HIV Cluster and Detection Response Team CHC Work Session	02/27/20
MSDH and MS Department of Corrections (MDOC) Incarcerated and Transitional Support Leadership Collaborative Work Session	03/13/20
Black Treatment Advocacy Network (BTAN) MS Leadership Collaborative Work Session	04/01/20
HRSA CBA Jackson Planning Group Work Session	04/10/20
CHC Work Session for Uptake on PrEP	04/27/20
City of Jackson Health Task Force Leadership Work Session	04/29/20
BTAN MS/BAI/MSDH: MS EtHE Statewide We the People Virtual Town Hall	05/12/20
Communities of Faith: Jackson Revival Center Town Hall	05/16/20
BTAN MS Northern and Central MS Focus Group Work Session	05/19/20
MS EtHE Task Force Latinx Leadership Listening/Work Session	05/28/20
MS Community Health Worker (CHW) Expansion Work Session	06/11/2020
BTAN MS/BAI/MSDH: MS EtHE Statewide We the People Virtual Town Hall	06/18/20
MS EtHE Task Force Latinx Leadership Listening/Work Session	07/15/20
MHPC/EtHE Task Force Strategy Meeting in Response to COVID-19	07/30/20
MSDH MS HIV Cluster and Outbreak Detection and Response Team Strategic Planning Meeting with CHC Association of MS	08/13/20
MHPC Retreat and MS EtHE Task Force Briefing	08/19-20/20
Transgender Education and Advocacy Project (TEAP) MS Leadership Listening/Work Session	08/26/20
MS EtHE Task Force EtHE Black Leader's Listening/Work Session	09/08/20
MSDH/MDOC EtHE Leadership Work Session on Support for Incarcerated and Transitional Support for Recently Released Individuals within MDOC	09/16/20
MHPC Statewide Virtual Meeting	10/02/20
CDC EHE Community Engagement Discussion: Mississippi	10/13/20
MS EtHE Task Force Transgender and Gender Non-Conforming (GNC) Leadership Work Session	10/22/20
BTAN MS/BAI/MSDH: MS EtHE Statewide We the People	10/27/20

Virtual Elected Officials Town Hall	
MS Ending the HIV Epidemic (EtHE) Initiative: Black Women/Women of Color Leadership Work Session	10/29/20
MS Ending the HIV Epidemic (EtHE) Statewide CHC Partnership Work Session	10/30/20
MS Ending the HIV Epidemic (EtHE) CBO Partnership Work Session	10/30/20
MS Ending the HIV Epidemic Task Force EtHE Jurisdictional Plan/Epi Profile Statewide Virtual Public Review	11/04/20
Ending the HIV/Epidemic Administrative CBO/CHC Proposal Review Work Session	11/09/20
MHPC Vote of Concurrence on the MS EtHE Jurisdictional Plan and Epi Profile	11/13/20
CDC/NASTAD Town Hall with Southern States on EtHE Community Engagement Efforts	11/17/20
MS EtHE Task Force Communities of Faith Work Session	11/18/20
MHPC Meeting	12/11/20
MS EtHE Task Force Meeting	12/14/20

Ongoing Community Engagement Activities

The variety of community engagement sessions with the highlighted several key themes: stigma; the need for government support of grassroots efforts; the importance of sustained community engagement in program design and implementation and the need for structural change in Mississippi. Several consultations highlighted social and racial justice, the importance of affirming terminology, and building and expanding sustainable programs. Moving forward MSDH will continue to engage community members at each step of the planning and implementation process.

The health department is in a unique place to incorporate innovative disruption by implementing programs designed for the priority populations that originate from the communities themselves. MSDH will work with community members who are underserved and have not received culturally, and linguistically appropriate healthcare services to evaluate the quality of services providers providing STD/HIV services render and to hold them accountable to their communities.

Community engagement efforts resulted in a discussion about the need to hold service providers accountable for providing culturally, linguistically appropriate service through the state. Over the next several months MSHD will work with the planning bodies on a policy and implementation steps to hold providers funding to offer STD and HIV services accountable to their clients and communities. All complaints of services rendered by clinics/providers providing STD/HIV services may be submitted in writing to the MS MHPC and the MS EtHE/ETE Task Force for review and resolution. Possible outcomes for such a policy may include the ability to report a service complaint to the MSDH, corrective action plans for providers, and the offering of additional cultural competency training.

Mississippians are energized and are working hard to End HIV in Mississippi. Strategies developed were based on suggestions community members submitted during various community engagement activities throughout the state and based on successful evidence-based models that have been proven to be effective in Ending HIV. HIV education and prevention are needed most among many vulnerable populations: any individual who is having sex, Same Gender Loving Men, Men and Women of Color, Transgender, and Gender Non-Conformant (TGNC) persons. For people living with HIV, EtHE/ETE activities will focus on providing increased culturally and linguistically appropriate HIV care and treatment including Rapid ART, retention in HIV care, viral suppression, concentrated on members of vulnerable populations with the most need.

The MSDH MS EtHE/ETE Task Force and its working groups continue to engage with the MHPC on the development of the plan. Additionally, planning continues for future town halls to ensure voices of community members of various target populations that have not traditionally been reached by the MSDH are consulted on challenges and best ways to move forward in implementing activities from the Plan that are most responsive to need.

The MSDH continues to meet regularly with the MHPC and the MS EtHE Task Force working groups to develop next steps and to implement additional suggestions. With the finalization of the EtHE plan, the work of the MHPC and the EHE Task Force will shift towards implementation and monitoring and evaluation of the plans included activities.

The people of Mississippi have spoken, the state can get to the end of HIV, but it can only happen with a collective impact approach of working together, and not by people and organizations working in silos.

Legislative Action Required

For Mississippi's EtHE/ETE plan to have maximum impact, action is required by Mississippi's Governor and legislature in three specific areas:

Medicaid Expansion:

Expanding Medicaid is critical to providing Mississippians whole-person healthcare that includes prevention, care and treatment services. By expanding Medicaid, thousands of Mississippians living with and at risk for HIV would have access to routine preventive care, doctor's visits, and prescriptions as well as PrEP and PEP allowing limited Ryan White dollars to go further in serving the uninsured.

HIV Decriminalization

Mississippi's current HIV criminal statute presents an enormous barrier to combating stigma in the state and to encouraging individuals to get tested for HIV and entering and staying in routine HIV care. The legislature must update the state's criminal code on HIV so that it is in line with the most current scientific and public health information/innovations. Mississippi must work to eliminate laws that serve as barriers to Ending HIV in Mississippi such as Code §97-27-14 that perpetuates these issues by including saliva, urine, and feces as a crime of endangerment by bodily substance, even though these substances have zero risk of transmitting HIV.

HIV and STD education

Unfortunately, Mississippi currently mandates an abstinence-only based health curriculum in its schools, leaving it up to school district jurisdictions to implement an abstinence-plus curriculum. Unfortunately, this leaves school-aged Mississippians without crucial information on sexual health and knowledge about HIV and STD transmission. The state legislature must ensure that all school districts include comprehensive age-appropriate sexual health education, alongside abstinence-plus messaging that include explicit discussion of HIV and STDs.

Situational Analysis

The HIV epidemic in Mississippi is among the most severe in the US and is characterized by profound racial disparities, a substantial burden of HIV in rural communities, and low rates of HIV care engagement and viral suppression. Relative to other US States, Mississippi has the 8th highest rate of HIV diagnosis among all adults and the 6th highest rate of AIDS diagnoses. In 2018 9,466 people were living with HIV in Mississippi. The rate of people living with HIV per 100,00 people was 381. Black Mississippians represent 37.4% of the state's population but accounted for 72.9% of people living with HIV and accounted for 76% of new diagnoses in 2018. The rate of Black males living with an HIV diagnosis is 5.5 times that of White males. The rate of Black females living with an HIV diagnosis is 9.4 times that of White females. The rate of Hispanic/Latino males living with an HIV diagnosis is 3.2 times that of White males. The rate of Hispanic/Latina females living with an HIV diagnosis is 4.8 times that of White females. Mississippi is one of seven states with the highest rural burden of HIV, with approximately 43%

of PWH in Mississippi living in rural counties, and an estimated 41% of individuals newly diagnosed with HIV in 2018 living in a rural county. Alarming, the rate of new HIV diagnoses increased by 12% from 2017 to 2018, making Mississippi the only US State (of those with an HIV diagnosis rate >10 per 100,000) to report an increase in new HIV diagnoses in the last year. Mississippi's inclusion in the federal EHE plan creates significant opportunities for the MSDH and its wide range of partners to invest in addressing HIV by creating new opportunities for prevention and care and bringing new sectors of society into the solution. While Mississippi's rates of new infections in the state are alarming, there are reasons to believe the state is poised to meet these challenges.

Intersectionality of Social Determinants of Health and HIV in MS

Many of Mississippi's poor health outcomes are due to social determinants of health (SDOH), conditions in which people are born, work, grow, and age. They are pivotal to individual health and community well-being, and their impact are just as great as biological factors that affect health. These circumstances are shaped by the distribution of wealth, power, and resources at the national, state, and local levels. They include:

In 2018, the CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) added social determinants of health to the NCHHSTP AtlasPlus. *Healthy People* (HealthyPeople.gov) developed a broad approach to identifying and addressing social determinants of health based on five categories: Economic Stability, Health and Health Care, Social and Community Context, Education, and Neighborhood and Built Environment. Several determinants are subsumed under the five categories, including food insecurity, affordable housing, and education. In addition to *Healthy People's* five broad categories and subcategories, the EHE will focus upon poverty, HIV and Aging, immigration status, mental and behavioral health, transportation, and housing. All are intricately bound to community engagement, education, and awareness. They underscore the importance of *place* to produce better outcomes for PWH.



Source: healthypeople.gov

Poverty

The American Community Survey (ACS) shows that the median household income for Mississippi in 2019 was \$45,792 compared to the national household income of \$65,712. The 2019 American Community Survey 1-year Estimates shows that 19.6% of Mississippians fall below the poverty line compared to the national poverty rate of 10.6%. At almost one-fifth or 20% below the poverty line, Mississippi has the highest poverty rate in the nation. Almost 84% (83.9%) of Mississippians have a high school education or higher compared with 87.8% nationally.

The Henry Kaiser Family Foundation placed the HIV diagnosis for adults and adolescents in Mississippi at 19.3%. When segmented by racial and ethnic demographics, 38.8% are Black/African American followed by 36.8% Hispanic/Latinx. American Indians/Alaskan Natives, Asians and Whites have lower rates at 8.4%, 7.5% and 6.5% respectively. Healthcare is critical to the early diagnosis and treatment of persons with HIV. However, 12.9 % of Mississippians are uninsured and 24.9% are on Medicaid. Many Mississippians who cannot afford health insurance could receive additional expanded coverage if the State Legislature expands the Medicaid State Program to provide additional coverage for individuals at risk for or living with HIV to ensure that all know their status and stay in care.

Immigration Status

The HIV Surveillance Report published by the CDC in 2020 for data collected in 2018 showed that 347 Latinx were diagnosed with HIV at a rate of 473.4 per 100,000 population. The diagnosis was second only to that of Blacks/African Americans at 761.1 per 100,00 population.² With a rate of 36.8% of all persons diagnosed with HIV in the State, Latinx Mississippians comprise the second largest group of persons diagnosed with HIV. Immigration and Customs Enforcement (ICE) raids carried out by the federal law enforcement officials in the summer of 2019 have made Latinx Mississippians even harder to reach due to the fear of being harassed or deported when trying to seek preventive or healthcare services. The fear of harassment and threat of deportation exacerbate adverse conditions such as isolation from community and healthcare services and a reduction in the likelihood of seeking preventive and interventive measures to quell the possibility of increased infections.

According to the CDC, HIV diagnosis is growing among Latinx persons, primarily MSM. Among reasons cited for the increase are lack of health insurance, distrust of the healthcare system, and language barriers. However, especially concerning is the lack of awareness about risk factors. Cultural factors are important, including stigma, fear, and discrimination among other concerns.

While increasing awareness through education holds significant currency in combatting some of the negative perceptions associated with HIV, it is not a panacea for addressing the unique issues faced by the Latinx population diagnosed with HIV. It can, however, help mediate the harm caused by a lack of knowledge about HIV transmission, treatment and reduce stereotypes associated with HIV.

Housing

Housing/Rehousing People with HIV (PWH) is one of the most challenging barriers to address in Mississippi. HIV-related stigma limits the number of affordable, quality units available to PWH.

² Centers for Disease Control and Prevention. HIV Surveillance Report, 2018 (Updated); vol. 31. <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published May 2020. Accessed December 8, 2020.

Housing Opportunities for Persons with AIDS (HOPWA) is a federally assisted housing program created to provide housing assistance and a variety of support services to low wealth persons diagnosed with HIV/AIDS. The initiative is administered by U.S. Department of Housing and Urban Development (HUD). Mississippi received several millions of dollars for HOPWA in 2020. Notwithstanding the ongoing funding support for HOPWA, support for PWH receiving housing and support services through HOPWA and similar programs has declined. The emergent demand for housing that accompanied COVID-19 improved response efforts in addressing additional housing needs of PWH.

Adequate and affordable housing remains a critical need for PWH. It is central to building community and promoting a sense of place. Ongoing community engagement and outreach are essential to linking the PWH population with direct and support services that enhance a desirable quality of life.

Mental and Behavioral Health

Individuals living with HIV face chronic and pervasive stigma and discrimination. This results in stress that contributes to the disproportionate prevalence of behavioral health problems, including depression, anxiety, psychological trauma, and substance use.

PWH who suffer from behavioral health problems often face the dual stigma of HIV and having co-occurring psychiatric diagnoses. PWH have unique needs for integration of culturally tailored behavioral health services into primary care, which can, in turn, improve engagement in HIV care, and lead to an increase in antiretroviral medication adherence.

PWH encounter numerous barriers to behavioral health treatment. Medical mistrust, discrimination within the health care system, poor integration of behavioral health and primary care services, as well as inadequate insurance or lack of insurance coverage for behavioral health treatment have historically contributed to behavioral health care disparities among PWH.

Transportation

Mississippi is a very rural state with limited areas with public transportation which is mostly located in Central and Southern regions of Mississippi. The average client that resides in rural Mississippi must drive at least two hours one way to get the services they need. Transportation can serve as a barrier to getting access to appointments, referrals, support services, and pharmacies for HIV Prevention and Care servicing to prevent the acquisition of HIV or prevent a person with HIV from becoming virologically suppressed. There is a need to expand transportation services to include more transportation options such as Uber and Lyft, incentivizing clients with travel gift cards, or providing clients with tele-prep internet data cards to know their status and stay in care.

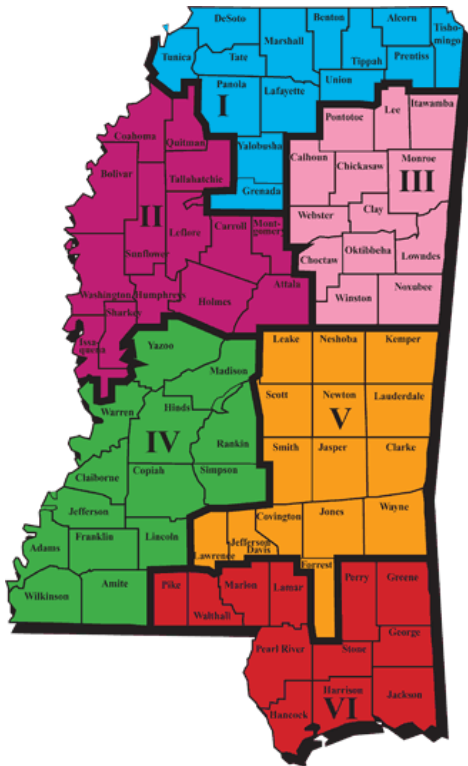
HIV and Aging

In 2018 the CDC recorded that of the 37,968 diagnosed with HIV, 17% were age 50 years and older. In addition to the regular health maladies and chronic conditions that sometimes accompany aging, living with HIV brings its own set of concerns that may complicate or be complicated by other health conditions.

Older individuals in Mississippi are more likely than younger people to have late-stage HIV infection at the time of diagnosis. People aged 50 and older may start treatment late, which may put this population at risk of more immune system damage. Therefore, increasing the number of individuals who receive antiretroviral therapy (ART), or Rapid ART is a priority of the Mississippi EtHE Plan.

Social determinants of health continue to inform where, how and with whom people live. It also determines for how long people live. Creating a viable sense of place where community reflects the successful, holistic integration of the social, cultural, natural, and built environments guides the work of EtHE in MS. The outcome is reflective of the MS EtHE Initiatives' commitment to raising awareness through orientation about the challenges of PWH and individuals most at risk for acquiring HIV/AIDS.

MS Epidemiologic Snap-Shot Diagnosis/Rates by Public Health District Summary



PHD I: HIV diagnosis (2018)- 55; HIV diagnosis rate- 16.6
PHD II: HIV diagnosis (2018)- 31; HIV diagnosis rate- 8.9
PHD III: HIV diagnosis (2018)- 44; HIV diagnosis rate- 21.5
PHD IV: HIV diagnosis (2018)- 34; HIV diagnosis rate- 9.9
PHD V: HIV diagnosis (2018)- 136; HIV diagnosis rate- 24.2
PHD VI: HIV diagnosis (2018)- 39; HIV diagnosis rate- 14.9
PHD VII: HIV diagnosis (2018)- 31; HIV diagnosis rate- 17.3
PHD VIII: HIV diagnosis (2018)- 57; HIV diagnosis rate- 17.6
PHD IX: HIV diagnosis (2018)- 53; HIV diagnosis rate- 10.3

Strategy 1: Diagnose all people with HIV as early as possible

HIV testing remains the cornerstone of HIV prevention efforts, but only 40.2% of Mississippians have ever been tested for HIV (44.3% in urban counties and 35.4% in rural counties) and only 12.7% (14.3% in urban areas and 10.9% in rural counties) were tested within the past year. In 2017, an estimated 16.8% of Mississippians were living with HIV but unaware of their HIV status, which represents an increase from 14.8% in 2014. The percentage of individuals newly diagnosed with HIV in 2017 who were diagnosed with AIDS within one year – i.e., “late HIV diagnosis”, a marker of infrequent HIV testing – was 29% in 2018. This has remained relatively stable in the past five years and is markedly higher for women than men (37% vs. 26%, respectively). Currently, only one community-based organization receives direct funding from CDC to provide HIV prevention services and it is in the urban center of Jackson.

Beginning in 2019, the MS Department of Mental Health (DMH) contracted with MSDH to implement an HIV testing program as required by federal mandate at eleven participating mental health regional facilities. DMH will also collaborate with MSDH to develop a statewide ending the HIV epidemic targeted communication strategy to destigmatize HIV/AIDS, stop the spread of HIV/AIDS, and increase awareness. Additionally, late in 2019, MSDH began working to develop a rapid HIV testing contract with Mississippi United to End Homelessness (MUTEH), which is a Housing Opportunities for People with AIDS (HOPWA) agency. MUTEH will commence testing when all contracting requirements are met.

All contracted MUTEH sites are provided Rapid HIV Testing training by HIV Prevention Branch staff. This training includes proper completion of an Evaluation Web (EvalWeb) testing template and reporting of preliminary positive results to MSDH. Additionally, contractors are required to provide prep education to HIV negative clients and verify linkage to care and services. The [Prep provider list](#) is included in the testing training conducted by staff.

Mississippi has a broad HIV exposure law that can be applied to any sort of HIV exposure. Mississippi’s felony exposure statute also includes Hepatitis B and Hepatitis C.³ Before HIV decriminalization can happen, capacity building and raising awareness must first occur and will be the focus of the efforts for the first year of this plan.

³ Center for HIV Law and Policy, 9/4/16 Access at <http://www.hivlawandpolicy.org/states/mississippi>

MSDH will scale up its testing efforts by expanding access points. currently, Mississippi offers HIV testing at 20 community testing sites, as well as all county health departments in the state. HIV Prevention staff is developing educational information for administrators and providers on guidelines for opt-out testing as well as perinatal testing. HIV prevention and education staff are also transitioning all contracted rapid HIV testing sites from the 20-minute testing devices to the sixty-second testing devices. This testing technology will facilitate more clients being tested and enhance patient flow within clinics.

Each of the three Community Based Organizations (CBOs) funded through the HIV Prevention Grant (PS 18-1802) have mobility and capabilities to conduct testing anywhere in the state. Each CBO schedules its events as well as attends health fairs, pop up and invited events. HIV prevention staff have met with the Community Health Center Association of Mississippi's (CHCAMS) Director of Strategic Partnership and other key stakeholders to explore further collaboration and expand or implementation of routine opt-out HIV testing. The office currently has Memoranda of Understanding (MOUs) for rapid HIV testing with twelve of the twenty-one community health centers in the state, which includes the six centers newly funded by HRSA through the federal EHE initiative. It is envisioned that through the life of the funding of this grant and collaboration with CHCAMS, other opportunities for improving routinized testing of all patients and development of mechanisms for rapid linkage to care and prevention will be accomplished. Funds will be allocated in the budget to cover laboratory costs for centers, not HRSA recipients and have high volume battery (including other STIs) testing. AIDS Health Care Foundation (AHF), CARE4ME Services, and My Brother's Keeper, with support from the MSDH, implement syphilis education and testing programs to further minimize the risk of HIV acquisition. CARE4ME's C-STEP (Community Syphilis Testing and Education Program) is a proactive community level syphilis prevention and education program designed to increase awareness and offer testing to reduce new cases of syphilis in the Jackson MSA. My Brother's Keeper advertises testing events on the Open Arms Healthcare Center website and through social media, conducts rapid syphilis testing on-site and on their mobile clinic, and provides educational information about risk factors, treatments, and resources. AHF promotes syphilis education through billboard campaigns and provides education and syphilis testing services. On average, the MSDH distributes condoms to approximately 100 organizations, including CBOs, barber, and beauty shops, ASOs, colleges, and universities and other organizations and community individuals. This does not include regular distribution to health departments. MOUs have been established with 39 organizations to conduct rapid HIV testing throughout the state. In addition to approximately 20 testing sites, subgrantees also provide testing services as well as at all MISSISSIPPI county health departments.

Strategy 2: Treat people with HIV rapidly and effectively to reach viral suppression

Unfortunately, Mississippi has still not expanded Medicaid under the Affordable Care Act. Estimates show that more than 261,000 Mississippians would be eligible for the expansion which would cover low-income individuals up to 138% of the federal poverty level. Currently, only parents with incomes up to 22% FPL qualify for Medicaid – there is no coverage avenue for

childless adults. In 2018, 46% of ADAP clients were at or below 138% FPL.⁴ Uncompensated care costs in Mississippi exceed \$600 million annually, according to a statement from the Mississippi Hospital Association. Estimates show that by expanding Medicaid, uncompensated care costs would decrease by 57%.⁵ Since the Mississippi legislature rejected Medicaid expansion in 2013, five rural hospitals have closed and 42% of rural hospitals are “vulnerable.”⁶

Recent Medicaid expansion victories in other states, coupled with the recent spotlight on health care and health disparities due to COVID-19 have reinvigorated conversations about the need to expand Medicaid to low-income Mississippians.

Per Mississippi’s surveillance report, in 2018, only 64% of individuals newly diagnosed with HIV were linked to care within 30 days. This represented a substantial decline since 2014 when 80% of individuals were linked to care within 30 days. However, in 2018 the percentage of new HIV diagnoses linked to care within 90 days was high (85%). The percentage of individuals living with HIV who achieved sustained engagement in HIV care in 2018 was 54% and the percentage who were virally suppressed was 44%. These percentages are both below the national average. Mississippi’s aim is to ensure activities undertaken as part of the EtHE initiative will have a substantial impact on rapid linkage to care, sustained engagement in care, and viral suppression.

In 2018, 4,392 PWH received services through the Mississippi Ryan White HIV/AIDS Program. Of that number, 82% were African American, 65.7% were male and 33.4% were female, 60.2% were 100% below the federal poverty level, 34.8% had no insurance, 95.3% reported being in stable housing, 84.5% were retained in care, and 84.9% achieved viral suppression. The Ryan White AIDS Drug Assistance Program (ADAP), which provided medications to more than 2,500 individuals in 2018, extended its Insurance Assistance Program (IAP) and continues to assist Ryan White eligible clients with Marketplace enrollment.

The MSDH Ryan White program has also expanded early intervention services through the UMMC CIRCLE (Cooperative for Innovative, Research and Clinical Engagement) program, a component of Express Personal Health. The “All-In at the CIRCLE” is a program that integrates a system for real-time identification of individuals not effectively benefiting from HIV treatment and a low-barrier care system. The program is dedicated to delivering HIV care to Ryan White Part B-eligible individuals living with HIV in the Jackson MSA to include improving the proportion of people living with HIV who are durably suppressed, providing clinical services, expanding intense case management and other social services.

4 National Alliance of State and Territorial AIDS Directors, *2020 National RWHAP Part B and ADAP Monitoring Project Annual Report*, Table 13, <http://publications.partbadap-2020.nastad.org/>.

5 Center for Mississippi Health Policy, *Medicaid Expansion: An Overview of Potential Impacts in Mississippi*, <https://mshealthpolicy.com/medicaid-expansion/>

6 The Chartis Center for Rural Health, *Rural Hospital Vulnerability*, February 2020,

https://www.chartis.com/forum/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FINAL-02.14.20.pdf

Sexual health clinics, like the Crossroads Clinic, serve populations at highest risk of HIV and are uniquely positioned to provide HIV testing, pre-exposure prophylaxis, post-exposure prophylaxis, and linkage/re-engagement to HIV care for persons of color. Through a project with Denver Prevention Training Center, *Scaling Up HIV Preventive Services in STD Specialty Clinics*, the STD/HIV Program will develop the infrastructure to collect and analyze program data to evaluate the effectiveness and gaps in HIV prevention services in sexual health clinics serving people of color. Under this project, technical assistance and training will be provided as part of a process of HIV prevention service expansion and continuous quality improvement will be driven by program evaluation metrics as data management infrastructure is developed. This partnership will enable readiness for implementation of a Rapid ART Initiation Model.

Crossroads Clinic will launch a virtual clinic in early 2021 focused on tele Prep, PEP, STD testing and treatment for patients across the State of Mississippi. Patients will be able to start medication at no cost for HIV Prevention (Rapid ART Initiation) and receive treatment for STDs at no cost and consult with a PrEP Navigator. Referrals will be made for linkage to care for the diagnosis of HIV. Currently, Mississippi is one of three sites selected for participation in the University of Alabama study, *Geographic Variability in Time from HIV Diagnosis to Viral Suppression in the Deep South: A Roadmap to Accelerated Treatment Initiation* that will inform the development of a rapid ART program.

Consistent with *Ending the HIV Epidemic: A Plan for America*, the MSDH Ryan White Part B Program proposed to pursue state-level strategies by focusing on *Pillar Two*: treat people with HIV rapidly and effectively to reach sustained viral suppression and *Pillar Four*: Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

The objective for pillar two is to expand access to HIV care and treatment for individuals living with HIV who have not been linked to medical care or have not had continuous medical care within the previous 12 months. *Pillar Four* involves identifying HIV clusters throughout Mississippi of PWH who need care and treatment and provide and ensure access to needed services to improve health outcomes. Key collaborators for the Ryan White EHE initiatives include the Southeast Regional AIDS Training Center, Mississippi Medical Association (MSMA), and the Mississippi Public Health Institute (MSPHI). Utilizing results of the MSDH STD/HIV Office Consumer Needs Assessment Survey, conducted by MSPHI, and released in January 2020, the program will be able to assess potential opportunities and limitations based on existing policies and funding to sustain HIV services through state-wide focus groups to solicit and receive feedback from primary care systems, faith-based organizations, nonprofits, and other partner organizations that may assist with ambulatory or support HIV services. The Mississippi State Medical Association (MSMA) is hosting a series of Lunch and Learn provider recruitment sessions with non-traditional providers to potentially engage in HIV care due to the limited availability of infectious disease physicians in the Mississippi. Dr. Claude Brunson, president of the association has agreed to serve as a provider recruitment champion.

Through the EHE Initiative, six Federally Qualified Health Centers (FQHCs): Aaron E. Henry Community Health Services Center, Coastal Family Health Center, Delta Health Center, Family Health Center, G.A. Carmichael Family Health Center, and Southeast Mississippi Rural Health Initiative also received funding in areas with the highest burden HIV infections to expand PrEP services.

Extensive collaboration is planned for six community health centers not receiving Ryan White funding. The centers will assist MSDH to provide rapid ART to positive patients. Also, all positive patients tested and confirmed at these centers will be provided with rapid ART. According to state rules and regulations, community health centers will forward positive tests report to the STD/HIV office for follow-up and partner notification.

Approximately 20 services providers located throughout the state, through subgrants or contracts enable an array of direct services to Ryan White Part B eligible clients that include oral healthcare, medical-case management, mental health, substance abuse, emergency financial services, including housing, transportation, food, and other support services. Eleven MSDH Social Work/Case Managers serving county health departments also work closely with providers to ensure clients are retained in care and to assist with prioritization of needs. The Ryan White Minority AIDS Initiative (MAI) continues to cost-share TB nurse support at the Mississippi Department of Corrections to complete and manage discharge planning for inmates who are living with HIV and are eligible for release. Through an MOA with the MSDH TB program, they also assist with outreach and referrals to coordinate ADAP enrollment for eligible inmates.

Mississippi acknowledges that housing is healthcare. Currently, the Mississippi Home Corporation administers the HOPWA program for the state. MSDH STD/HIV Program partners receiving HOPWA support from the city include MUTEH and Grace House. Emergency housing assistance is provided through the AIDS Services Coalition in Hattiesburg for Ryan White Part B enrolled clients. Several agencies in the state provide housing opportunities via the HOPWA program funded by the Department of Housing and Urban Development. Agencies providing HOPWA services include: AIDS Services Coalition in Hattiesburg, Grace House in Jackson and the Mississippi United to End Homelessness (MUTEH). However, MUTEH is unable to assist additional persons due to lack of resources.

Strategy 3: Prevent new HIV transmission by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs)

Mississippi has one of the lowest rates of PrEP uptake nationally, particularly among Black men who have sex with men (MSM) and women. According to Siegler et al, Mississippi has the second lowest PrEP-to-need ratio (the ratio of PrEP users to new HIV diagnosis), indicating that PrEP uptake in Mississippi is incredibly low relative to the number of individuals newly

diagnosed with HIV.⁷ Despite current local attempts to facilitate access to PrEP, uptake remains low. Several possibilities that contribute to low uptake including, access to a PrEP provider, stigma, financial barriers, and awareness about PrEP. According to data from the PrEP Locator, Mississippi has one of the lowest numbers of PrEP providing clinics per new HIV diagnosis (5th worst in the country).⁴ As part of the EtHE initiative, new activities to better monitor PrEP uptake in the state and promote more widespread PrEP uptake are being proposed.

In late 2019, CBOs launched a pilot in partnership with Express Personal Health Clinic and Open Arms Healthcare Center for Tele-PrEP. MSDH and collaborators will continue to increase education and awareness of PrEP availability if Mississippi were to expand Medicaid. MSDH and its collaborators will continue to work and increase the number of PrEP providers through the MS AETC, Gilead clinical scientists, and the PrEP detailers.

Strategy 4: Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them

Currently, tests conducted at public health clinics and specimens collected are submitted to the Public Health Laboratory (PHL). The specimens are processed, and results are received within 3-5 days via Electronic Laboratory Reporting (ELR) by the STD/HIV office staff. The LTC/RTC Coordinator will contact contracted CHCs to ensure positive patients receive rapid ART and linkage. Simultaneously, the three regional coordinators within the office will generate Field Records (FRs) and forward them to statewide DIS to conduct follow-up, linkage to care, and partner notification. This process will ensure each positive person receives rapid ART within 7 days.

⁷ Aaron J. Siegler, PhD, et al, *the prevalence of pre-exposure prophylaxis use and the pre-exposure prophylaxis-to-need ratio in the fourth quarter of 2017, United States*, *Annals of Epidemiology*, Volume 28, Issue 12, December 2018, <https://www.sciencedirect.com/science/article/pii/S1047279718301078>

Mississippi Ending the HIV Epidemic Plan Activities

Detailed below are strategies and activities in each of eight (8) goal areas that MSDH will undertake to End the HIV Epidemic and provide high-quality services to Mississippians. While all activities are critical to ending HIV in Mississippi and addressing co-occurring conditions, the MSDH has noted foundational and other priority activities to be implemented at the beginning of the MISSISSIPPI EHE Plan.

The overall goal of the EtHE plan is to reduce the number of individuals newly diagnosed with HIV by 50% by 2025. Metrics are for the first four goals are detailed in the chart below.

1. <u>Diagnose all people with HIV as early as possible</u>	
<p>Metrics</p> <ul style="list-style-type: none"> • <i>Knowledge of HIV status:</i> Increase the percentage of individuals aware of their HIV status by 90% by 2025. • <i>Late HIV diagnosis:</i> Decrease the percentage of individuals who are diagnosed with HIV late to less than 20% by 2025 	
Strategy	Activities
<p>Strategy 1A. Expand or implement routine opt-out HIV screening in healthcare and other institutional settings in high prevalence communities</p>	<p>Year One</p> <p>Update educational presentation regarding opt-out testing, perinatal screening and reporting requirements and protocols. Ensure dissemination and training.</p> <p>Create testing tool kit for clinics detailing common implementation challenges, tried solutions and snapshots of success.</p> <p>Initiate discussions with Medicaid program to reimburse for routine opt-out HIV testing, not just medically necessary testing. Develop letter to be sent by Medicaid to all Medicaid providers in state regarding opt-out HIV testing recommendations and information on PrEP.</p> <p>Subsequent Years</p>

	<p>Continue implementation of Emergency Department HIV testing programs in two rural safety net hospitals. Identify additional hospitals to approach for implementation of testing program</p> <p>Continue working with all FQHCs in state to ensure implementation of routine opt-out HIV testing. Provide technical assistance on clinic flows and offer mentoring with other clinics who have successfully implemented for entire patient population. Ensure Rural Health FQHCs understand requirements and, if at the beginning stages of providing HIV prevention and care services, link with another FQHC for mentorship.</p>
<p>Strategy 1B. Develop locally tailored HIV testing programs to reach persons in non-healthcare settings</p>	<p>Year One</p> <p>Increase the number of community agencies to include Mississippi Department of Corrections sites (MDOC), Mississippi Department of Mental Health (MDMH) and additional community organizations providing routine opt-out testing.</p> <p>Work with Latino/a and Transgender community leaders to better understand facilitators of and barriers to increased testing and linkages to care. Follow recommendations with new testing providers. Consider placing regional Latino/a and Transgender testing coordinators in organizations in key areas in the state.</p> <p>Subsequent Years</p> <p>Develop new agreements with community agencies to offer HIV testing alongside other community services. For existing agencies amend contracts with targets for number of tests.</p> <p>Review existing and new testing data and existing testing contracts to ensure testing is being implemented sufficiently amongst priority populations and in rural areas. Based on data provide technical assistance to existing agencies and/or seek out additional partners to provide deeper reach into priority populations.</p> <p>Work with HBCUs to increase promotional messages around HIV/STI testing, increase peer mentors on campuses</p>

<p>Strategy 1C. Increase at least yearly re-screening of persons at elevated risk for HIV infection per CDC testing guidelines, in healthcare and non-healthcare settings</p>	<p>Year One Begin project to adapt clinic EHRs to include HIV testing guidelines. Pilot adaptation in clinics with highest positive test results.</p> <p>Subsequent Years Provide additional funds or staff in clinics in high prevalence areas to ensure testing and linkages are completed.</p> <p>Conduct community assessment and focus groups to better understand community needs and perspectives regarding testing programs available and existing gaps. Use data to developed tailored testing programs aimed at underserved populations and where data shows greatest undiagnosed cases (i.e., youth, Black gay men)</p>
<p>Strategy 1D. Increase use of more effective testing technologies</p>	<p>Subsequent Years Work with all contracted organizations and clinics to begin using sixty second testing devices to increase testing flows and patient satisfaction.</p> <p>Implement self-test program. Work with CDC project officer to identify technical assistance resources</p>

Workforce Needs: The MISSISSIPPI DOH will work to expand its workforce using partnerships in existing and expanded testing sites.

Community Engagement Needs: Provide input and feedback into social media campaigns initially focused in most prevalent areas of states; assist in developing community assessments to better understand needs, barriers, and challenges for specific populations of Mississippians

2. Treat people with HIV rapidly and effectively to reach sustained viral suppression

Metrics

- *Linkage to care Within 7 days:* Increase the percentage of newly diagnosed individuals linked to care within 7 days to 65% by 2025
- *Linkage to care within 30 days:* Increase the percentage of newly diagnosed individuals linked to care within 30 days to 95% by 2025

- *Viral suppression within 6 months:* Increase the percentage of newly diagnosed individuals with a viral load <200 copies/mL (within 6 months of initial diagnosis) to 90% by 2025.
- *Receipt of HIV care:* Increase the percent of all people living with HIV who at least one viral load of CD4 lab in the past 12 months to 75% by 2025.
- *Re-engagement in HIV care:* Increase the percentage of all individuals with a suppressed viral load among those confirmed to be out-of-care (within 6 months of outreach by MSDH) to 75% by 2025.
- *HIV/AIDS standardized mortality ratio:* Decrease the standard mortality ratio of people living with HIV relative to the general population by 25% by 2025.

Strategy	Activities
<p>Strategy 2A. Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV</p>	<p>Year One Investigate feasibility of implementing rapid-start programs in jails in highly impacted counties.</p> <p>Ensure routine generate of SAS code to evaluate timeliness of laboratory reporting and entry of labs in eHARS is being conducted effectively. Provide technical assistance to providers with reporting delays.</p> <p>Subsequent Years Develop educational overview of rapid start programs for providers in Mississippi to assist in increasing program coverage throughout state. Establish sub-grantee agreement with community health centers and/or community-based organizations (CBOs) for rapid linkage to HIV medical care, essential support services, and early ART initiation.</p> <p>Collaborate with the Epidemiology and Laboratory Capacity (ELC) Cooperative Agreement staff increase timely reporting of all new HIV diagnoses by identifying large volume reporters that are not sending HIV related labs electronically.</p> <p>Pilot rapid-start programs in Univ. of MISSISSIPPI Medical Center emergency departments that are currently providing routine opt-out testing.</p>

	<p>Collaborate with non-Ryan White providers based on HIV-positive test results to promote and support rapid linkage and early ART initiation and establish agreement with non-Ryan White providers reporting a large volume of new HIV diagnoses</p>
<p>Strategy 2B. Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Program (RWHAP)</p>	<p>Year One Discuss re-engagement of NIC patients with the community to learn their concerns and barriers and increase health department communication.</p> <p>Hire dedicated Re-engagement to Care (RTC) Coordinator: RTC Coordinator will monitor and maintain re-engagement data; re-assign field records to the HIV Case Managers (CMs) for follow-up; communicate with HIV CMs to ensure timeliness of NIC documentation in PRISM; update eHARS with RTC outcomes.</p> <p>Subsequent Years Bi-annually (January and July), generate not in care (NIC) list using CDC supplied SAS code. Work with HIV case managers to conduct outreach. Ensure that process is as streamlined and comprehensive as possible.</p> <p>Work towards a more real-time data system which allows for response to client needs based on more integrated and accessible data system used by both STI and HIV DIS and case managers.</p> <p>Match eHARS with CAREWare and Medicaid data to help accurately identify persons presumed to be not in care. Explore other data sets to be added to data match to create more robust dataset.</p> <p>Collaborate with providers to expand (D2C) activities HIV care providers complete and submit form to the health department for individuals who have missed appointments or maybe out of care according the provider’s NIC definition</p>

	<p>Consider additional funding/staffing in subsequent budgets at clinics with highest numbers of HIV-positive clients to conduct reengagement activities.</p>
<p>Strategy 2C. Increase services designed to adherence to ART.</p>	<p>Year One Work with HRSA and other partners to identify creative solutions to ongoing transportation challenges, especially in the rural area of the state.</p> <p>Implement health literacy campaign designed to educate people with HIV and the public on how ART adherence leads to viral suppression which means that people have no risk of transmitting HIV to their sexual partners.</p> <p>Subsequent Years Conduct assessment of current ADAP clients to understand what facilitates and prevents the daily taking of their medications. Based on feedback received consider implementing programs designed to increase adherence including use of technology and apps; pharmacist interventions; and options for medication pick-up including on-site pharmacies.</p> <p>Assess housing needs of RW clients and other people with HIV. Work with HOPWA program and other housing agencies to increase stable and long-term housing options for people with HIV. Examine feasibility of expanding short-term housing via Ryan White funds.</p>
<p>Strategy 2D. Decrease barriers to accessing and staying in care.</p>	<p>Year One MSDOH will research and implement a training program for all staff at subgrantee and contracted agencies to receive baseline training on trauma-informed, culturally competent care and racial and implicit bias in healthcare delivery.</p> <p>Subsequent Years MSDOH will review all administration processes including the application and recertification process for RW Part B and ADAP services to ensure streamlining and aligning the processes across providers and decreasing duplicative data supplied by case managers and clients.</p> <p>Explore implementing low-barrier and walk-in/on-demand care with clinics seeing greatest number of people with HIV. Work with AETCs or other partners to discuss availability of clinic resources to implement this in-person or via increased telemedicine capabilities.</p>

	Explore and implement innovative ideas aimed at increasing retention and adherence such as financial incentives (gas cards, grocery stores, gift cards), provision of food boxes at appointments, transportation and ensuring that people can see multiple medical providers in same appointment block, if necessary.
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Workforce Needs: Ensure hiring of Re-engagement to Care Coordinator to assist medical case managers with ensuring all re-engagement activities are completed across the state. Hire additional disease intervention specialist (DIS) to conduct to work with re-engagement for out-of-care. Position will conduct follow-up on disease and partner notification; work with social workers and CAREWare to perform acuity assessments, determine eligibility and make appointments. Focus on ensuring baseline training for all staff at clinics and community-based organizations delivering HIV prevention and care services. Work with clinics to better understand their staffing needs to increase rapid start programs and increase routine opt-out testing.

Community Engagement Needs: Engage community on training for clinic and CBO staff; provide input into better meeting transportation and housing needs.

3. <u>Prevent new HIV transmissions by using proven interventions, including PrEP and SSPs</u>	
Metrics	
<ul style="list-style-type: none"> • <i>Knowledge of PrEP:</i> Increase the percentage of individuals aware of PrEP to 95% by 2025 • <i>Screening for PrEP:</i> Increase the percentage of individuals who are screened for PrEP to 85% by 2025 • <i>Uptake of PrEP:</i> Increase uptake of PrEP to 50% by 2025 • <i>Retention on PrEP at 4 months:</i> Increase retention on PrEP to 75% by 2025 	
Strategy	Activities
Strategy 3A. Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP	<p>Year One</p> <p>Increase Tele-PrEP usage. Reevaluate access points to expand network for access.</p> <p>Develop state-wide educational campaign using influencers, social media, and state leaders on availability of PrEP and ways to access.</p>

	<p>Develop advisory on nonoccupational postexposure prophylaxis (nPEP) for health providers in state on best practices and CDC recommended guidelines. Develop corresponding educational piece for communities and work with community partners on dissemination.</p> <p>Subsequent Years Analyze STI and HIV testing data to guide prioritization of clinics and geographic areas for enhancement and expansion of PrEP services.</p> <p>Hire additional PrEP navigator to ensure appropriate level of coverage throughout state and to provide training to staff at high-volume clinics, those new to providing PrEP and those in underserved regions of the state.</p> <p>Work with the over 150 contracted HIV testing sites and MSDH clinics to develop and implement a standardized screening tool for PrEP. Add screening requirement to testing site contracts and require data on activity.</p> <p>Increase number of PrEP providers and detailers, particularly in underserved areas.</p> <p>Ensure all testing sites and entering PrEP screening and referral data into EvalWeb, analyze data and provide feedback to testing sites, as necessary.</p> <p>Identify clinics with highest HIV testing rates and work to increase linkages and referrals for PrEP.</p> <p>Educate providers on HHS Ready, Set, PrEP program and Gilead patient assistance program.</p>
<p>Strategy 3B. Increase availability, use, and access to and quality of comprehensive syringe services programs (SSPs).</p>	<p>Year One Work to educate state leaders and legislators to expand provisions for SSPs. Ensure understanding of statistics on HIV transmission due to injection drug use and importance of SSP in providing prevention, screening, linkage, and testing services to population.</p> <p>Subsequent Years</p>

	<p>Work with community to understand what agencies in state are conducting harm reduction activities, absent of syringe exchange. Work to ensure testing for HIV and HCV is available and that referral and linkage systems are in place for healthcare and substance use services.</p> <p>Work to increase transmission data completeness in surveillance system to ensure transmissions via injection drug use are being captured.</p>
<p>Strategy 3C. Increase the availability of co-located screening, testing and prevention services for HIV, STIs, hepatitis C and substance use.</p>	<p>Year One Work with the Mississippi Department of Mental Health to ensure screening and testing for HIV and HCV at Community Mental Health Centers. Reach out to diagnostic and testing companies for assistance with donated products to begin a pilot project in heavily impacted areas.</p> <p>Subsequent Years Work with CDC Hepatitis Coordinator to increase screening and testing for hepatitis C (HCV); identify clinics to participate in pilot program to increase HCV screening and testing for injection drug users. Ensure labs are reporting HCV infection to health department. Begin discussions on building HCV surveillance system to inform outbreak and risk-factor based programming.</p> <p>Reach out to the Delta Opioid Task Force and other regional efforts to seek out opportunities for testing and linkage to services.</p>
<p>Strategy 3D. Increase scientifically based, age-appropriate sexual health education through Mississippi</p>	<p>Work with education agencies within Mississippi, policymakers, state leaders and community throughout the state to expand HIV and STI information offered in schools. Develop workplan with timeline with action steps to develop legislation requiring school districts to offer abstinence-plus education which includes age-appropriate HIV and STI messages.</p> <p>Work with network of colleges and universities to offer HIV and STI messages and screenings at all campuses in state.</p>

Workforce Needs: MSDH will consider hiring at least one PrEP navigator and providing funds in most impacted regions of state for PrEP coordinators to providing training to clinic and CBO staff and provide navigation services to ensure referrals, linkages, and adherence to PrEP. Work with surveillance program on hepatitis C reporting and analysis.

Community Engagement Needs: Develop PrEP education and social media campaign with community input. Discuss role that SSPs play in preventing new HIV transmissions and linking drug users to health and substance use services.

4. Respond quickly to potential outbreaks to get needed prevention and treatment services to people who need them.

Metrics

- *Surveillance for real-time cluster detection:* Increase the proportion of HIV labs entered into the surveillance system within two weeks of specimen collection to 85% by 2025
- *Completion of genotype sequencing:* Increase the percentage of people newly diagnosed with HIV with genotype sequence reported to MSDH to 70% by 2025
- *Response to HIV transmission clusters:* Increase the percentage of individuals identified as members of priority clusters who are located and interviewed within 7 days of identification to 65% by 2025
- *Outcomes of cluster investigation among people living with HIV:* Increase percentage of people living with HIV identified in a cluster who are not adequately engaged in HIV care who are linked back to care to 75% by 2025
- *Outcomes of cluster investigation among people who are HIV-negative:* Increase percentage of people who are HIV-negative who are associated with a cluster who start on PrEP to 75% by 2025

Strategy	Activities
<p>Strategy 4A. Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response</p>	<p>Year One</p> <p>Increase capacity to conduct follow-up investigations of cases with insufficient information (e.g., missing race/ethnicity; missing risk factor information) or potential cases with insufficient information (e.g., a reactive rapid test without a supplemental test to confirm infection) to establish an HIV diagnosis.</p> <p>Develop feedback tool for health care providers, facilities, or laboratories with missing or incomplete information for required data elements.</p> <p>Subsequent Years</p>

	<p>Meet monthly with MSDH STD/HIV Cluster Detection and Investigation Team to discuss cluster related activities including provider and laboratory reporting; feedback to providers and labs; CD4/VL prioritization protocols; completeness of documented negative HIV results in surveillance system</p> <p>Establish a sub-committee of the MS HIV Planning Council to engage community members when developing strategies related to Cluster Outbreak Detection and Response.</p> <p>Expand mechanisms and processes to expedite reporting and entry of key data in surveillance systems to ensure accurate surveillance data for members of the local communities in planning, implementation, and evaluation:</p> <p>Improve methods of collecting documented negative HIV test results for persons with diagnosed HIV infection. Investigate laboratory reports suggestive of incomplete reporting of the recommended laboratory-based testing algorithm and indicative of possible recent infection.</p> <p>Increase capacity to enhance routine data linkage of eHARS records with other data sources. (Medicaid, Care Ware, STD/Database, Jails, Vital records, Atra Black Box) and perform Soundex and Accurint searches on individuals prior to entry into the surveillance system.</p> <p>Identify CBOs and other subcontractors that will support HIV cluster response efforts.</p> <p>Draft agreements with subcontractors reflective of the mechanisms that require subcontractors to redirect a portion of their funding to support cluster response.</p>
<p>Strategy 4B. Investigate and intervene in networks with active transmission</p>	<p>Identify case prioritization of network members for enhanced linkage and other essential support services.</p> <p>Assess need for additional training of key staff to implement methods to identify and understand the entire network, focusing on the following areas:</p>

	<ul style="list-style-type: none"> • Enhanced Partner Services • Case, partner, and cluster (i.e., non-sexual social contacts interviewing) • Forms and procedures for documenting case, partner, and cluster information
Strategy 4C. Identify and address gaps in programs and services revealed by cluster detection and response	<p>Year One Develop local measures for evaluating cluster response.</p> <p>Subsequent Years Utilize CDC provided Cluster Information Report to identify gaps and services. Plan for after-action report/evaluation</p>

Workforce Needs: MSDH plans to hire an additional epidemiologist to assist in surveillance activities and to manage data for EHE dashboard and reports. Ensure sufficient staffing and clear roles and responsibilities within surveillance team

Community Engagement Needs: Establish Subcommittee of Mississippi HIV Planning Council to advise the HD on cluster and outbreak activities.

5. Increase access to effective and comprehensive care across the state	
Strategy	Activity
5a. Identify and implement programs aimed at increasing whole health services for Mississippians living with HIV	<p>Increase health services in underserved areas of the state using telehealth and by investing in capacity of existing clinics. Focus telehealth expansion on rapid start programs and behavioral health services</p> <p>Implement robust health insurance purchasing program for current and new ADAP clients, saving the ADAP program money and provides clients with more robust coverage for HIV and co-occurring conditions. Work with client to provide assistance with premiums, deductibles, and co-pays. Work towards purchasing insurance for all eligible ADAP clients.</p> <p>Ensure policymakers, community members and state leaders understand the important role that Medicaid plays for people living with HIV.</p>

	<p>Incorporate community health worker program into outreach, retention and adherence programs in PrEP and treatment programs.</p> <p>Engage in series of ongoing conversations with state Medicaid about need to increase retention in care and viral suppression rates for Mississippians with HIV who are enrolled in Medicaid.</p>
<p>5b. Increase revenue to HIV response to reinvest in increasing service delivery across state.</p>	<p>Work with HRSA technical assistance providers to identify opportunity to increase revenue via billing and 340B generated by health department programs and in clinics throughout the state. Develop coordinated plan to use revenue generated to fill critical gaps in service needs including housing and transportation.</p> <p>Ensure clinics and contracted agencies understand opportunities for revenue generation regarding service delivery. Invest in technical assistance provider to increase revenue generation at local health departments, CBOs, and other partners across the state.</p>

6. Decrease stigma and provide life-affirming messaging and care	
Strategy	Activity
<p>6a. Implement programs and messages with the explicit goal of decreasing HIV and related stigmas</p>	<p>Implement statewide anti-stigma campaign focusing on education about current science of HIV and including the following messages: “undetectable = non-transmittable,” “know your status,” “Stop Stigma,” and “I did it.” Use policy leaders, social media influencers in area and community members. Include community members, policy experts, faith-leaders and others in development and implementation of campaigns. Ensure that state and localities are working with diverse set of partners including fraternities and sororities, NAACP, faith-based organizations, and other social service organizations.</p> <p>Engage with AETC to implement peer mentoring for clinicians and clinics newer to providing HIV care.</p> <p>Increase opportunities for paid positions for people with HIV at community organizations.</p>

	<p>Increase clinics using sexual health model to engage clients in prevention and care services – look at replicating “Becoming a Healthier You” model used at the Open Arms Healthcare Center in Jackson, MS to other areas with high STIs and HIV testing.</p> <p>Utilize population-based community groups such as the Transgender and gender non-conforming leaders, Black gay and bisexual men and Black women of color leadership groups to develop curriculum to train peer navigators utilizing a community health worker model to provide education, peer support and linkages to prevention and care services throughout the state.</p>
<p>6b. Increase focus on role HIV criminalization plays in HIV stigma and access to prevention and care.</p>	<p>Work with MS HIV Planning Council, community members, legal experts, and others to educate community, the public and policy makers about the negative role HIV criminalization plays in preventing new HIV infections and linking HIV positive people to care.</p> <p>Assess how MS’ HIV criminalization laws impact priority populations as laid out in this plan. Share information with policymakers and community.</p> <p>Engage law enforcement and prosecutors in discussion about MS criminalization laws, surveillance technology and science of HIV transmission and present and MS assessments and data.</p> <p>Develop one-pager aimed at educating the public and showing how the MS criminal code should be updated to be in-line with current science and <u>Department of Justice Best Practices Guide to Reform HIV-Specific Criminal Laws to Align with Scientifically-Supported Factors</u>.</p>
<p>6c. Ensure funded prevention and care service providers deliver culturally and linguistically competent care to Mississippians</p>	<p>Develop tiered accountability process in which the MS HIV Planning Council can receive complaints from patients. MSHPC will work with MSDH and named service provider to resolve issues raised. As part of this process, lay out policies and procedures for consideration.</p>

7. Identify, address, and reduce health disparities

Strategy	Activity
<p>7a. Develop or enhance tailored interventions designed to complement foundational activities and further decrease disparities seen in men who have sex with men, Black individuals, Latinx individuals, Transgender individuals, and young people.</p>	<p>Ensure newly developed educational and social media campaigns are developed with community input and messages that resonant with each impacted population.</p> <p>Ensure that the MS HIV Planning Council has representation from disproportionately impacted positions and that input from others not on the Planning Council is routinely sought on and included in development and implementation of programming.</p>
<p>7b. Use data to drive programming and clear communications with community, state leaders and policymakers.</p>	<p>Ensure combined data set (Ryan White, surveillance, STDs, Medicaid data match) includes all possible data and routinely conduct analysis by population and geographic areas. Share data with MS HIV Planning Council to determine where to invest new resources and programming.</p> <p>Begin plan to develop data dashboard as part of MSDH website to share completed analyses.</p>

8. Increase MSDH capacity to develop new, innovative partnerships that are responsive to the needs of the individuals most at risk for acquiring HIV in MS

9.

Strategy	Activity
<p>8a. Ensure adequate health department staffing so that all core functions and new activities are implemented and sustained</p>	<p>Work to identify a technical assistance provider to conduct an analysis of health department staffing, roles and responsibilities and provide recommendations on more efficient staffing models and positions to be filled.</p> <p>Work with state health department leadership to ensure that all open positions and new positions needed to implement the EHE plan are quickly filled.</p> <p>Work with CDC & HRSA on comprehensive, implementable & integrated technical and capacity-building assistance plans.</p>

<p>8b. Ensure core functions happen routinely and to public health standards</p>	<p>Work with CDC to investigate possibility of placing a CDC detailer in MS to ensure HIV surveillance program and all affiliated activities are in place and that the systems and processes being used meet public health standards.</p> <p>Work with testing partners in the state to increase the number of complete HIV surveillance reports, including HIV risk factor and demographic data including sexual orientation and gender identity data (SOGI).</p> <p>Hire contractor to optimize use of CAREWare and provide integration opportunities for HIV and STD surveillance and lab reports with CAREWare and other public health data, including Medicaid.</p>
<p>8c. Ensure key community and other partnerships to augment and broaden the reach of health department functions</p>	<p>Using health department analysis identify potential partnering opportunities with key community organizations to increase reach of health department staff and programs.</p>

Partnerships

The MSDH has engaged a broad roster of partnerships in place including the following to facilitate the implementation of the priority activities and continue to engage the community.

Partner	Focus Activities
University of Washington	Surveillance and epidemiology technical assistance
MS State Office of Rural Health Programs	Community engagement in rural counties
Southeast AIDS Education and Training Center	Serves the HIV/AIDS educational needs of Health Care Providers in Mississippi and throughout the Southeast. Provides comprehensive, collaborative educational opportunities designed to increase the size and strength of the HIV clinical workforce. Works to empower providers to improve outcomes along the HIV Care Continuum, with the goal of reducing the rate of new HIV infections.
Mississippi AIDS Education and Training Center	Develops and provide training, capacity building opportunities and technical assistance that is responsive to community and health department needs such as HIV education and other related needs.
NASTAD	Provides capacity building and technical assistance for community members and the health department to ensure that programming and activities are responsive to need. Represents public health officials who administer HIV and hepatitis programs in the U.S. It works to accomplish its mission to end the intersecting epidemics of HIV, viral hepatitis, and related conditions.
Community Health Prevention Intervention Education Research (CH-PIER), THRIVE SS, Inc.	Ongoing meaningful engagement with people with HIV
MS Decriminalization Network, MS Center for Justice	Support efforts to educate and empower the community and law makers about the importance of decriminalizing HIV in MS as a tool to End HIV in MS
Working Together Mississippi/Trabajando Juntos Mississippi	Engagement with Latinx communities
TEAP MS, with ACLU of Mississippi	Engagement with transgender and gender non-conforming communities
MS in Action	Engagement with black women
One Vision Solutions	Engagement with LGBTQIA organizations and communities
Mississippians United to End Homelessness (MUTEH)	Engagement with unstably housed populations and implementation of programs to increase housing availability and stability

Keri Johnson Behavioral Health Services	Engagement with people with use drugs and implementation of programs to increase integrated HIV and behavioral health services, increasing understanding of critical need for SSPs in Mississippi
Straughter Counseling	Focus on increasing mental health services that are responsive to need
Community Health Centers Association of MS	Increasing role of rural health FQHCs in providing HIV and STD prevention and care services; developing MS HIV Detection and Cluster Response Plan
Mississippi Department of Corrections	Increasing HIV prevention and rapid start programs in houses of corrections
Community Health Workers Network of MS	Developing MS HIV Detection and Cluster Response Plan; increase use of community health workers in engagement most impacted populations and sustained use of HIV care services
Institute for the Advancement of Minority Health	Works to reduce health disparities among disadvantaged and underserved minority populations in the southern region through program development and implementation, training and technical assistance, organizational capacity building, grant writing and evaluation. The areas covered by the Institute include all 82 counties of Mississippi.
JMW Consulting	Contractor for statewide EtHE/ETE Community Engagement efforts
Mallory Community Health Center	Increase access, coverage in rural and hard to reach areas of the state by expanding care team to include a Community Health Worker (CHW) that is a member of a target population most at risk for acquiring HIV/AIDS in MS as outlined in EtHE plan, expand HIV Cluster Detection and Response Team by joining, being active and by working to expand support network.
Jackson-Hinds Comprehensive Health Center	Increase access, coverage in rural and hard to reach areas of the state by expanding care team to include a Community Health Worker (CHW) that is a member of a target population most at risk for acquiring HIV/AIDS in MS as outlined in EtHE plan, expand HIV Cluster Detection and Response Team by joining, being active and by working to expand support network.
Jefferson Comprehensive Health Center	Increase access, coverage in rural and hard to reach areas of the state by expanding care team to include a Community Health Worker (CHW) that is a member of a target population most at risk for acquiring HIV/AIDS in MS as outlined in EtHE plan, expand HIV Cluster Detection and Response Team by joining, being active and by working to expand support network.
Five Horizons, Inc.	Increase access, coverage in rural and hard to reach areas of the state by expanding care team to include a Community Health Worker (CHW) that is a member of a target population most at risk for acquiring HIV/AIDS in MS as outlined in EtHE plan, expand

	HIV Cluster Detection and Response Team by joining, being active and by working to expand support network.
Outreach Health Services, Inc.	Increase access, coverage in rural and hard to reach areas of the state by expanding care team to include a Community Health Worker (CHW) that is a member of a target population most at risk for acquiring HIV/AIDS in MS as outlined in EtHE plan, expand HIV Cluster Detection and Response Team by joining, being active and by working to expand support network.



MHPC

The Mississippi HIV Planning Council

Letter of Concurrence

Between The MS HIV Planning Council (MHPC) and MS State Department of Health (MSDH)

December 11, 2020

Centers for Disease Control (CDC)
Nelson A. Colon-Cartagena (CDC/DDID/NCHHSTP/DHPIRS)
Grants Management Officer
Grants Management Branch, Procurement and Grants Office
Funding Opportunity Announcement: PS19-1906
Component B MS ETHE Jurisdictional Plan and Epi Profile Submission
1600 Clifton Road
Atlanta, GA 30333

Dear MSDH Prevention CDC Project Officer:

The Mississippi HIV Planning Council (MHPC) concurs with the following regarding the attached submissions by the Mississippi State Department of Health (MSDH) in response to Funding Opportunity Announcement: PS19-1906 Component B ETHE Jurisdictional Plan and Epidemiologic Profile Submission:

- The MS HIV Planning Council (MHPC) has reviewed the MS Ending the HIV Epidemic Jurisdictional Plan and its Epidemiologic Profile that was and will be informed by the MHPC and the MS Ending the HIV Epidemic/The Epidemic Task Force annually. The documents, in compliance with the Centers for Control and Prevention, are being submitted by the Mississippi State Department of Health, which concurs that the jurisdictional plan includes existing prevention programmatic resources to be allocated throughout the state to the areas with the greatest HIV disease burden and must respond to the needs of the individuals most at risk for acquiring STD/HIV in Mississippi as outlined in plan.

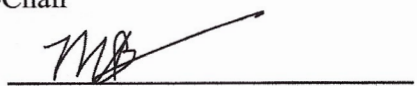
Approved and Adopted

Cedric Sturdevant
MHPC Community Co-Chair

Signature: 

Date: 12/11/2020

Melverta Bender
Director, MSDH Office of STD/HIV
MSDH Co-Chair

Signature: 

Date: 12/11/20

Appendix A



MHPC

The Mississippi HIV Planning Council

Membership Directory

Name	Employer	Membership Category/Type	County
Derrick Bean	Delta Health Center	Organization: Contracted FQHC	Bolivar
Melverta Bender	MSDH-STD/HIV Director *MSDH Co-Chair	Organization: HIV Service Provider	Hinds
Dr. Billy Brown	VA Medical Center	Organization: HIV Service Provider	Hinds
Decorreyon Burnside	AIDS Services Coalition - PIER	Individual: Community Advocate	Washington
Tara Cameron	MSDH – RW Pharmacist	Organization: HIV Service Provider	Hinds
Juanita Davis	Jackson Medical Mall – CARE4ME Services	Organization: Contracted Community Based Organization	Hinds
Linda Dixon, Esq.	MS Center for Justice	Stakeholder	Hinds
Dr. Eileen Ewing	Dept. of Mental Health	Organization: HIV Service Provider	Hinds
Kathy Garner	AIDS Services Coalition	Organization: Contracted Community Based Organization	Forrest
Sherry Stephens- Gibson	University of Mississippi Medical Center - AETC	Organization: HIV Service Provider	Hinds
Monica Gilkey	G. A. Carmichael Family Health Center	Organization: HIV Service Provider	Madison
Tonya Green	Southeast Mississippi Rural Health Initiative	Organization: HIV Service Provider	Forrest

Sherry Hawkins	Sacred Hearts Southern Mission	Organization: Sacred Hearts Southern Mission	Desoto
Aubri Hickman	University of Mississippi Medical Center – Adult Special Care RW Part C	Organization: HIV Service Provider	Hinds
Evonne Kaho	Love Me Unlimited 4 Life	Individual: Community Advocate	Hinds
Joseph Lindsey	My Brother’s Keeper South	Organization: Contracted Community Based Organization	Forrest and Harrison
Katymay Malone	Mississippi University for Women	Individual: Community Advocate	Lowndes
D’Kerio McGee	Region 8 Mental Health	Individual: Community Advocate	Hinds
Classie McMurry	Aaron E. Henry Community Health Center	Individual: Community Advocate	Panola
Marcus McPherson		Individual: Community Advocate	Hinds
Maria Morris	Community Health Center Association of Mississippi	Stakeholder	Hinds
Chad Neal	Crossroads Clinic North – RW Parts B&C *MHPC Co-Chair Elect	Organization: HIV Service Provider	Washington
Tshaka Nichols	Friends for Life	Organization: HIV Service Provider	Shelby (Tennessee) & Northern MS Counties
Brenda Patterson	Contact the Crisis Line	Organization: Contracted Organization	Hinds
Lisa Ross	Magnolia Medical Clinic – RW Part C	Organization: HIV Service Provider	Leflore
Joyce Roundtree-McCoy		Individual: Community Advocate	Bolivar

T’Juan Rucker	Mississippi HOME Corporation	Stakeholder	Hinds
Joe L. Smith		Individual: Community Advocate	Hinds
L. Nicole Stringfellow	FABRIC, Inc.	Individual: Community Advocate	Bolivar
Cedric Sturdevant	AIDS Services Coalition– PIER *MHPC Co-Chair	Individual: Community Advocate	Washington
Mark Vortice	Aaron E. Henry Community Health Center	Organization: HIV Service Provider	Coahoma

Appendix B – Ending the HIV Epidemic Task Force Roster

MS EHE TASK FORCE MEMBERS

<u>Task Force Member</u>	<u>Organization</u>
Selma Alford	MSDH, Office of Health Equity, Translational Services
Antiny Barnes	Community Member
Andrew Bates	University of Mississippi Medical Center (UMMC)
Melverta Bender	Mississippi State Department of Health, MS EHE Project Director
Dr. Mike Bookhardt	Family Medicine Physician
Rita Brent	Comedian/Community Activist
Stephanie Burks	Community Member/Professor/State Youth Director
Kizmet Cleveland	PHAROS, Inc., Community Health Center Association of Mississippi (CHCAMS)
Jemma Cook	Transgender Education and Advocacy Project (TEAP) MS
Reggie Davis	Community Member, Graphic Designer
Victor Easley	Community Member, Business Owner
Courtney Easter	Southern Health Commission
Rymsky Evans	Community Member
Shannon Fuller	University of California, San Francisco
Gerald Gibson	Community Member/My Brother's Keeper, Inc
Monnba Goat	Community Member
Darryl V. Grennell	City of Natchez, MS, Mayor
Telvin Harrington	Community Member
Viki Jackson	MSDH STD/HIV Staff Member/Community Member
Jermaine Jenkins	Community Member
Atlantis Johnson	MSDH Care and Treatment, Community Member
Kerri Johnson	Kerry Johnson Behavioral, Health Services, Inc., Behavioral Specialist
Aaron Jones	Community Member / My Brother's Keeper

Landros Jones	CARE4ME, Inc.
Jose Lucar Lloveras	UMMC, Infectious Disease Doctor
Chokwe Lumumba	Mayor, City of Jackson, MS
Richard Mac	Community Member
Jensen Matar	ACLU MS, TEAP MS
Marreo McDonald	Teen Health MS, COO
Dr. Sandra Melvin	Institute for the Advancement of Minority Health
Dr. Leandro Mena	UMMC, Infectious Disease, Doctor, UMMC Dean of Population Health
Mauda Monger	My Brother's Keeper, Inc., Community Advocate
Dr. Kesha O'Reilly	Gilead Sciences, Concerned Citizen
Brittany Overton	Community Member, OverZolli and SheGyver Custom Designs LLC
Lorena Quiroz	Working Together Mississippi -Trabajando Juntos Mississippi
Courtney Reynolds	Community Member
Dr. Chris Roby	MS Health Alliance, L.L.C, Community Health Center Association of Mississippi (CHCAMS)
Tammy Runnels	Medical Services/Mississippi, Division of Medicaid, Program Nurse III
Horace Russell	Internal Medicine Physician
Keyshia Sanders	City of Jackson, MS, Constituency Services
Talia Straughter	DBC, LPC Inc., MBK, Inc., Psychologist
Tridai Taylor	Community Member, Taylor Mark Consulting, Inc.
Dr. Danielle Thomas	City of Jackson, HR II Practitioner (Representative), Personnel Department
Roderick Thornton	Mississippians United to End Homelessness
Chigozie Udemgba	MSDH, Director of the Office of Health Equity
Dr. Joan Wesley	JMW Consulting, Jackson State University Department of Urban and Regional Planning
David Wiley-Long	BTAN MS, Black AIDS Institute
Joey William	Community Member
Shalom Williams	Community Member

Melody Wright	Community Member
Tony Yarber	Former Mayor, City of Jackson, MS
Charlita Zollicoffer	Community Member, OverZolli and SheGyver Custom Designs LLC

Appendix C – Black AIDS Institute Community Engagement Report In-depth Interviews and Reports on In-person and Virtual Events

BAI In-Depth Interviews

Greenville Demographics and Process

In Greenville and the Mississippi Delta, the BAI team conducted five in-depth interviews. The interviewees were recommended by a group of three partners BAI engaged in the Greenville area. BAI did two initial calls for background information with this group, which informed the strategy for the interviews, focus group, and town hall. Each interviewee knew that they would receive a \$50 Amazon gift card by mail after completion of the required forms and interview. In addition to a consent form, each interviewee completed a demographic form asking questions about their identity. Completion of the form happened ahead of the calls. Table 1 shows the demographic information of the participants.

Respondent	Gender	Sexual Orientation	Race	Age	City/Neighborhood
1	Woman	Heterosexual	Black	52	Metcalfe
2	Woman	Heterosexual	Black	65	Greenville
3	Man	Heterosexual	Black	69	Indianola
4	Man	Gay	Black	27	Greenville
5	Man	Heterosexual	Black	43	Greenville

Greenville Discussion

The interviews lasted approximately one hour and included questions about the respondents' views related to HIV in their community, stigma, and how MSDH could support their community. A few main themes emerged during these discussions, as discussed below.

Stigma

Stigma was a pervasive issue throughout the interviews. The sixth question of the interview focused on this topic (see interview questions in Appendix C) and was often mentioned at other points.

People discussed stigma as being directly related to HIV. One respondent stated, "It comes up when people admit they are HIV positive. Other people get to talking and they don't want to be labeled as an HIV-positive person. Then it goes into the fear that they are not being treated correctly." Respondents expressed that HIV stigma can manifest in the community through fear of sharing utensils or plates with people whom they think are living with HIV, or even not sitting in the same pew at church. They were clear that stigma affects anyone who is *perceived* to be living with HIV, regardless of whether they are or not. Stigma is also compounded by the insularity of these communities- people do not trust that employees at clinics will protect their privacy, and therefore

consider leaving the geographic region to seek care elsewhere so that their status is not shared with the community. Of note during the group discussion was that stigma does not only affect the person living with HIV but also those closest to them-- family and friends.

Participants also discussed HIV stigma as a creation of other stigmas around sex and sexuality. One participant likened the outlook toward the LGBTQIA+ community as being “still in the 1980s.” Some respondents said this was due to the religious views of their community. Another participant described the stigma she feels because she has a gay sister. LGBTQIA+ stigma within itself impacts views of HIV in Greenville and the Mississippi Delta. Similarly, stigma about having “too much” sex or being “promiscuous” affects people as they even consider getting an HIV test, seek other types of STI tests, or even getting a take-home test. One respondent discussed that this stigma leads to upholding abstinence-only education in schools, despite evidence that other types of sexual education are more effective.

A final note on the discussion of stigma is that it affects how people feel they can participate in sharing information about HIV. Many respondents shared that they were doing [this] work because they saw firsthand the stigma a loved one faced after a diagnosis, and/or had been themselves subjected to stigma. The respondents felt they would be comfortable sharing a post on social media that spoke to HIV education and prevention. However, one respondent added that he would be comfortable doing so if “it was not promoting a certain lifestyle.”

Building Coalitions

Another recurring theme in the interviews was the importance of building coalitions to have widespread HIV education campaigns. One respondent said they would like to see “people in each segment who have a voice” speaking about HIV. Having trusted leaders in different parts of the community- whether in different professional fields or of different faiths, was deemed important to disseminating information about HIV. It was also viewed as vital to dispelling stigma associated with HIV.

Racism

There was a range of viewpoints related to how racism influences conversations about HIV and the effect on Black communities. Comments reflected that HIV is not viewed as a problem because of the perception that [it] only affects Black people, the issue of white providers whose comments can alienate black patients, and that HIV stigma rather than racial discrimination, was the driving factor.

Hattiesburg Demographics and Process

The BAI team conducted two in-depth interviews with individuals referred by a local community-based organization serving the community of Laurel/Hattiesburg. Each interviewee was informed that they would receive a \$50 Amazon gift card by mail after completion of the required forms and interview.

Interviewees were required to complete both a consent form and a demographics form before the interview calls. Table 2 shows all the demographic information.

Respondent	Gender	Sexual Orientation	Race	Age	City/Neighborhood
1	Woman	Heterosexual	Black	48	Hattiesburg
2	Man	Gay	Black	37	Hattiesburg-Midtown

Hattiesburg Discussion

The interviews lasted about an hour and included questions about the respondents' views about Stigma, access, and education, and challenges with ending the epidemic.

Stigma

The participants talked about the role that stigma plays in HIV in Hattiesburg. One participant stated that, "Stigma is still the number one reason people are still diagnosed with HIV." "Stigma is one of those things we can't write a referral for and fix."

Access and Education

"The two biggest issues in Hattiesburg is access and education-respondent." Both participants talked about the need for sex education in schools including gay sex as a part of the curriculum. One of the respondents shared that more students are participating in gay sex than people realize, and they may be putting themselves at risk because they are unaware of all the resources that are available for them, which is why including gay sex as a part of the curriculum is necessary. A participant shared a personal story about their observation of access to condoms in a Wal-Mart in a predominately Black and White neighborhood. In the White neighborhood, condoms are out on a shelf where anyone could access them. In the Black neighborhood, condoms were under lock and key, which meant a person would have to ask an employee to open the cabinet so they could access condoms. For some, it's too much of a risk in a small community that someone would be exposed for purchasing condoms (young or older individuals).

Challenges with Ending the Epidemic

Each participant was asked if they believe we can end the HIV epidemic by 2030. The respondents had different answers. One respondent said yes if certain conditions were met such as universal health care and increased access in underprivileged communities. According to the respondent if more individuals without health care, especially the underprivileged, acquire healthcare coverage then it would be possible to achieve the goal. The other respondent said that Hattiesburg would not get to the end of the epidemic in the next 10 years and outlined challenges that must be addressed:

- Infrastructure within the HIV workforce including the health department. "Money is not what we need, we need infrastructure. More clinics in rural communities, a focus on literacy overall, and jobs so people can provide for themselves. "A number of people would fall through the cracks if we didn't have the Ryan White program because we are a state that hasn't expanded Medicaid.
- Address racial disparities and discrimination.

- Hattiesburg is a “hub city” (an hour and a half from Mobile, AL, Jackson, MS, and New Orleans, LA there must be collaboration with other states/cities that impact the Hattiesburg epidemic).

Focus Groups

Greenville Demographics and Process

The focus group involved 8 people, recruited by the same contacts in Greenville. These participants were also asked to sign consent and demographic forms. They were also informed that they would receive a \$50 gift card by mail after the focus group. Table 3 below shows the demographics of the respondents. Note that the focus group skewed younger than the in-depth interviews. (For more information on the Focus Group logistics please see Appendix D.)

Respondent	Gender	Sexual Orientation	Race	Age	City/Neighborhood
1	Woman	Heterosexual	Black	49	Moorhead
2	Woman	Heterosexual	Black	25	Greenville
3	Woman	Heterosexual	Black	36	Indianola
4	Woman	Heterosexual	Black	33	Metcalfe
5	Man	Gay	Black	23	Metcalfe
6	Man	Declined to list	Black	25	Greenville
7	Man	Gay	Black	27	Greenville
8	Man	Gay	Black	26	Greenville

Greenville Discussion

The focus group questions can be found in Appendix B. The focus group lasted about 90 minutes and covered the same questions as the in-depth interviews.

Education

The focus group participants drew attention to the lack of HIV education and awareness in Greenville and the Mississippi Delta. Many said that people do not know the basics of how HIV is transmitted, much less about newer concepts like PrEP and U=U. Some of this education was characterized as apathy- people felt that HIV did not concern them therefore they were not open to learning more about prevention and treatment. Lack of education may contribute to reluctance to get an HIV test and may also contribute to anxiety about getting a positive test result. Minimal knowledge of advances in HIV treatment is also a barrier to testing.

Stigma

This group had a very robust conversation about stigma, which was cited often as a driving force that made people afraid to seek out information about HIV, HIV testing, or to disclose their status. HIV stigma was also described in conjunction with homophobia, which would discourage people from seeking information about HIV out of fear of being labeled “gay”. Homophobia did not only affect those who were seeking care, but also those already engaged in the care continuum. One participant brought up an example of a young Black gay man who was accused of “promiscuity” by

a nurse at a health center. This led to the question as to whether patients are being treated according to the standard of care.

As in the in-depth interviews, participants discussed the issues that stigma created for HIV education, prevention, and treatment. They pointed to people traveling to other regions for testing and treatment and spoke of a culture of silence about HIV and sexual health, which reinforces the erroneous idea that it is not an issue in their community.

Limited Resources

Throughout the focus group, participants discussed the limitations of getting HIV testing and care. Many said that there is a limited pool of physicians comfortable with prescribing PrEP, for example. Similarly, there are only a few places to access HIV testing and HIV care throughout the region. Of the existing locations, some people might feel uncomfortable accessing services because of stigma as discussed earlier.

Racism

As with the in-depth interviews, racism came up as a factor in the HIV rates in the Delta. Many discussed this in terms of the relationships with white service providers. They expressed microaggressions from the health service providers, and again, this engendered questions about the quality of care they were receiving. Participants also discussed structural racism- pointing out that with HIV and even with COVID-19, the Black community was at a disadvantage because of the large proportions of people without health insurance and access to healthcare.

Dissemination of Information

The focus group participants had many opinions about how to best disseminate information about HIV. The consensus was that it should be geared toward “everyone, not just gay people or anything specific.” Participants recommended all forms of media, including billboards, radio ads, and digital media ads. They also recommended reaching out to preachers to talk about HIV in their services. Religious leaders were seen as crucial to normalizing conversations about HIV.

Grassroots Efforts

Throughout the conversation, respondents discussed the grassroots efforts that they saw making a difference in their community. Many said that they had not been plugged into HIV work until they met others who encouraged them to share their own stories or to raise awareness around HIV. This community work, although relatively small in scale, was discussed as an effective method to raise community awareness of HIV.

Hattiesburg Demographics and Process

The focus group involved 5 people. The participants were not able to participate all at once. Three individuals participated on July 30 and two on July 31. These participants were also asked to sign consent forms and demographic forms. They also knew they would receive a \$50 gift card by mail after the focus group. Table 4 below shows the demographics of the respondents.

Respondent	Gender	Sexual Orientation	Race	Age	City/Neighborhood
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1	Woman	Heterosexual	Black	32	Hattiesburg
2	Woman	Heterosexual	White	40	Hattiesburg
3	Woman	Heterosexual	Black	41	Greenville
4	Woman	Heterosexual	Black	49	Hattiesburg
5	Woman	Gay	White	62	Hattiesburg

Hattiesburg Discussion

What do you love about Hattiesburg? The city is a university of town that is more progressive than most of the state of Mississippi. The city is big enough not to be boring but small enough to know your neighbors. The city government is more progressive than most of the state. Hattiesburg is a hub city, so you are less than two hours to more major cities (Mobile, Alabama; New Orleans, Louisiana; and Jackson, Mississippi)

What are the areas of improvement? Disappointed the mayor didn't pass a hate crime ordinance. Another participant mentioned their disappointment in the city's plan of addressing the homeless population. The city government can't solve the problem by itself but hasn't done a great job with messaging to the community that everybody's help is needed to address it.

HIV Knowledge

HIV knowledge for the city overall is low. It's perceived by some that HIV is no longer an issue because it's not marketed in the city anymore. One participant stated that it's horrifying the lack of HIV knowledge by the community and the university community as well. The group felt like the education level of HIV was better in the '80s than it is now in Hattiesburg

Ending HIV

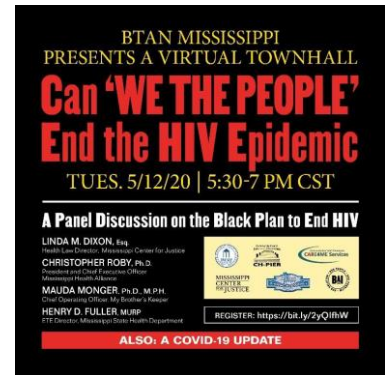
Mississippi healthcare policy (Lack of Medicaid Expansion, Antiquated HIV Criminalization Law not Based on Science) coupled with stigma will prevent the state from ending HIV and it make it difficult to get to end HIV. The stigma the community faces is cultural, religious, and really impact the populations at greatest need as well as testing, getting into, and remaining in care. The current plan and policy around PrEP and PEP and lack of access to these services all influence whether the outcomes will be favorable of ending the HIV epidemic. Another respondent addressed HIV criminalization being a barrier including outdated laws on the books such as spitting on someone being a crime if a person has HIV. "Ten years is not a long time and with the current structure we have we won't end it." A respondent stated "look at what we are going through now with COVID-19, people are not making decisions about what affects our community. That's the same thing with HIV, people are making selfish decisions not to protect others." Other barriers include a lack of education of policy makers. Some don't want to be educated about HIV. Another barrier is lack of infrastructure. There are not enough agencies providing HIV services including testing.

Town Halls

Recruitment

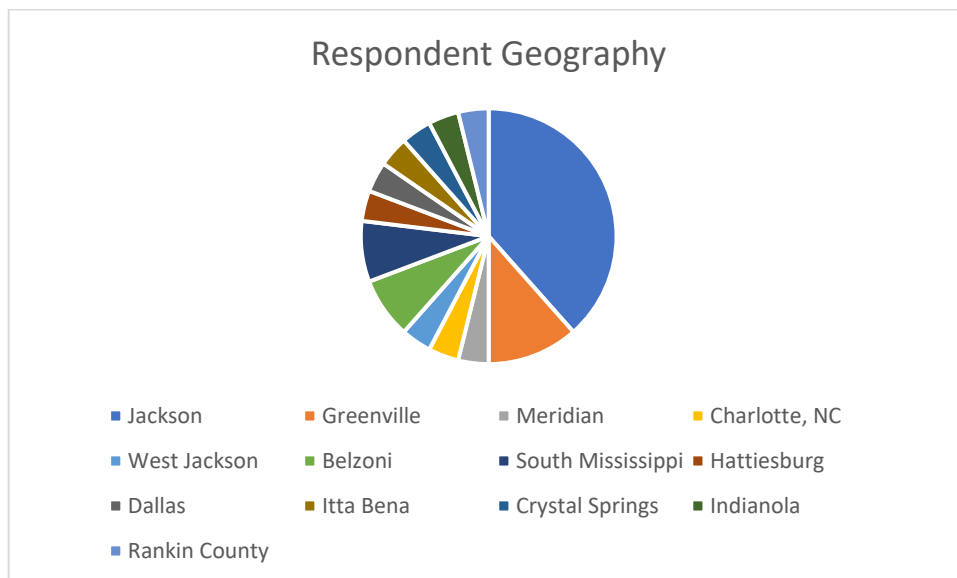
Recruitment for town hall participation was through word of mouth and social media. An important partner in recruitment was the Mississippi chapter of the Black Treatment Advocates Network

(BTAN). This program, administered by the Black AIDS Institute, brings together people living with HIV, healthcare advocates, and other stakeholders to create community projects about the HIV epidemic in Black communities. The Mississippi chapter is very active in both Jackson and the Delta and was able to spread the word about the town hall. 102 people registered for the town hall and 70 people ultimately joined the town hall held on May 12th, 2020 via Zoom, Facebook Live, and conference call.

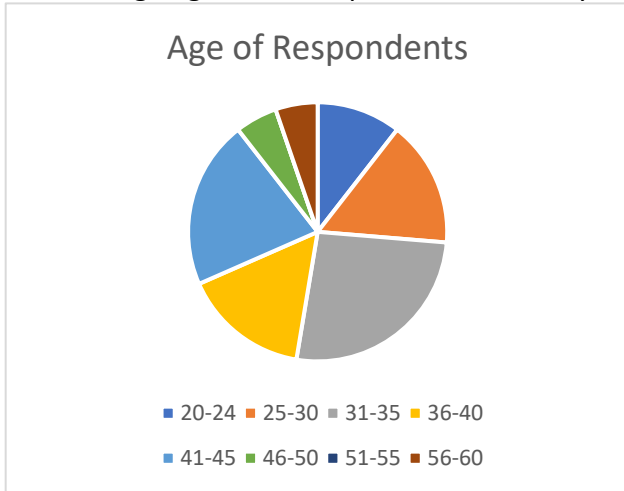


Demographics

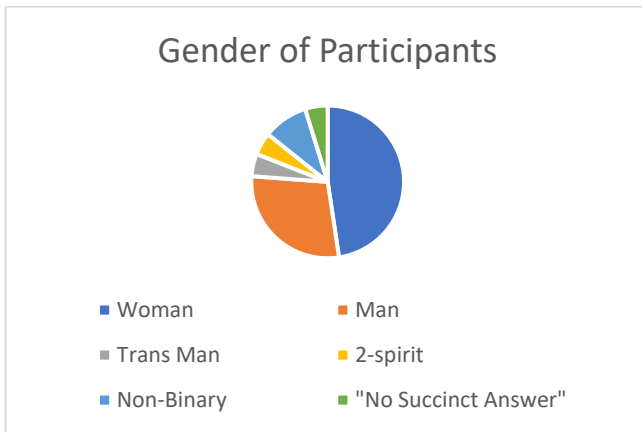
The town hall was originally planned as an in-person event that would allow community members from all walks of life to hear from and speak to members of the health department. As the COVID-19 pandemic progressed, the town hall was transitioned to a virtual platform. Hosting a virtual event also allowed people from throughout the Mississippi Delta and beyond who previously may not have been able to attend an in-person event to participate. Most of the respondents identified as Black, with one white person and one person identifying as multi-racial. No one identified as being of Latinx descent. This information, and the information below, was taken from the exit surveys. Of the 70 attendees, 23 people responded to the interviews.



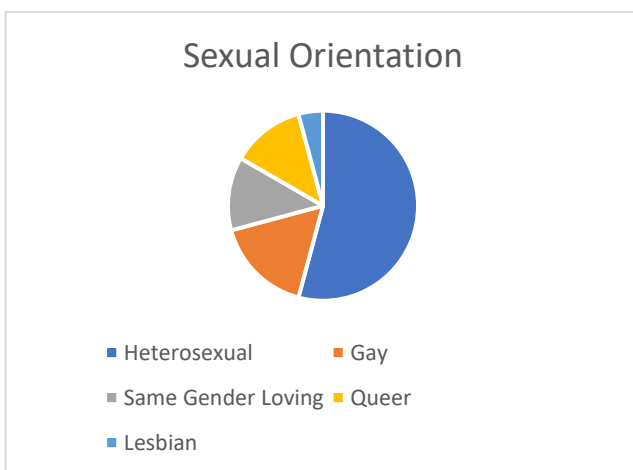
The average age of the respondents was 40 years old, ranging in age from 22-60.



Of the participants, there was also a wide representation of gender identities.

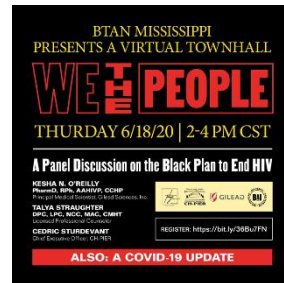


Similarly, different sexual orientations were represented.



Panelists and Structure of Town Hall

The town hall was produced in conjunction with the Black AIDS Institute's "We The People" Campaign. This campaign was created in response to the national plan to end HIV, and centers on the needs of Black communities, with the understanding that the HIV epidemic in the United States will only end if it ends in Black communities. The "We The People" Campaign encourages Black communities to build coalitions around the country to access the resources they need to address the epidemic. Maxx Boykin of BAI was one of the panelists and presented on the work of this program. Leisha McKinley-Beach, the lead consultant on this project, gave background information about the national plan to ensure that all participants were up to speed. The other panelists were local to Mississippi. They included Dr. Mauda Monger of MBK Inc., a health center in Mississippi; Linda Dixon of Mississippi Center for Justice, a nonprofit, public interest law firm committed to advancing racial and economic justice; and Christopher Roby of Mississippi Health Alliance. Additionally, there was a presentation by Henry Fuller of the Mississippi State Department of Health.



The panelists each presented about the work of their organizations and took questions from the audience about HIV work across the state.

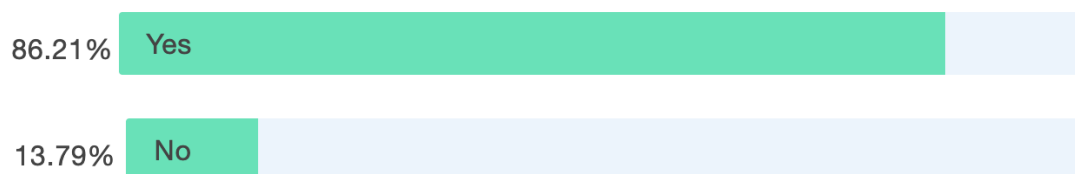
Discussion

Participants were able to ask questions and give feedback live during the call, by adding questions and comments in the chat box, and through the follow-up survey. The same questions were asked in the follow-up survey to allow for input from participants who may have felt uncomfortable during the group discussion.

Familiarity with HIV Resources in the Community

1 of 1. Are you familiar with HIV resources in your community? (Choose 1)

Multiple choice with single answer



Many respondents said they were familiar with the HIV resources in their community. Throughout the conversation, people spoke about testing sites and places where people can receive HIV care. However, less common were comments about PrEP or PEP. This answer may only reflect the resources people are aware of such as condoms, tests, and treatment.

In addition, in the follow-up survey, and in the comments, many people noted that the presentations were informative. This might be interpreted as a case of people not realizing their gaps in knowledge.

How do you feel HIV affects your community?

Many respondents shared personal stories of losing loved ones or community members to complications due to HIV. At the same time, respondents noted that they saw an increase in educational efforts around HIV. Still, many participants spoke about lingering stigma, and because of [that], as one person commented that they “do not see the path toward ETE” at this time.

One respondent posed a question that showed the tension around HIV stigma: “How can people living with HIV become more engaged in leading this work while they suffer from discrimination?” Stigma does not only affect how people access care it also affects how people can do the necessary work of leading initiatives and educating their community.

Another important point that came up was the additional barrier created by COVID-19, specifically for those who lost employment because of the pandemic. As the respondent noted, if people cannot take care of their basic needs such as food and housing, maintaining their medication regimen is even more difficult. Any initiatives that aim to address HIV at this time should consider these current realities.

What organizations do you think should be involved in EHE plans?

As the panelists discussed the work of their organizations, the participants were asked which organizations should be involved in crafting EHE plans. The most common responses were people living with HIV, community-based organizations that represent them, and medical researchers and providers. There were also answers which pointed to different facets of civil society such as sororities, churches, and the NAACP, and the need for HIV work to be grounded in a broad coalition building.

How can the government support the Black community through EHE?

These answers tracked with the responses to the previous questions. Many respondents spoke to the need for education: both community education and affirmative, informative sex education in schools. Many respondents called for the meaningful inclusion and support of PWH and for government to supply funds to organizations led by PWH.

On a more structural note, respondents also highlighted the need for Medicaid expansion, which was described as integral to HIV efforts in Mississippi. Similarly, many respondents cited Mississippi’s HIV criminalization laws as highly stigmatizing and problematic for any efforts to end the HIV epidemic.

How can we support each other during COVID19?

This final question was added to the conversation about HIV to allow space for people to discuss their urgent needs. Even though this event happened in May, and the COVID-19 pandemic is quickly changing, it is worth noting some of the enduring sentiments. Respondents asked for more informational sessions that had an uplifting tone; the stress and uncertainty of the pandemic was acknowledged, but people still wanted to learn more about COVID-19. There were also comments about the need to support people in community care: people want guidance to be able to check on each other, connect each other to resources, and share information.

HIV Symposium – Defeating the Stigma

This virtual town hall was held on May 16, 2020, via Zoom and Facebook Live and was planned in conjunction with the Jackson Revival Center to engage and educate members of the faith community about current EHE efforts. Individuals throughout Central MS were invited to join the conversation about Ending the HIV Epidemic in MS and urged to join the MS HIV Planning Council. Participants were also provided with an overview of the EHE goals nationally and locally. In addition, the community could provide feedback by asking questions throughout the presentation, participating in attendee polls from attendees and in the virtual chat room. 47 Mississippians engaged in this conversation.



Latino Leadership Consultation

The Latino Leadership Consultation, held on June 2nd, 2020, with six leaders and a representative from the health department and Gilead Sciences (these representatives, including the facilitator, did not identify as individuals of Hispanic/Latino ethnicity). According to Dr. Leandro Mena, Mississippi has the highest rate of HIV in Latino/Hispanic communities in the entire country. Therefore, it's important to create a strategy specifically for Hispanic/Latino communities in Mississippi. The group addressed some critical topics to developing a statewide plan to provide HIV services for the Latino/Hispanic community.

Terminology

The group discussed appropriate terminology when referencing the Latino/Hispanic population. The term Latinx was coined by millennials, is gender-neutral, and is acceptable in the Northeast and among millennials. Older Latinos are not as comfortable using that term, which means being of Latin decent. Hispanic includes people from Spain. A larger portion of people favored Latino vs. Hispanic, so the group came to the consensus to use the term Latino/Hispanic.

Social Justice Best Practices for Latino/Hispanic Community

One leader of the consultation stated they don't believe there are any best practices for Latino/Hispanic in the state of Mississippi. These conversations have led to a plan to apply for grant funding for this population now that attention is being placed on the Latino/Hispanic community. However, the system continues to operate with a "top-down" approach instead of identifying what are the true needs for this community. Any best practice model must address:

- Extensive research to understand the Latino/Hispanic communities of Mississippi
- Identify ways to ensure the Latino/Hispanic population is counted accurately in the census so adequate resources are allocated for this community
- Organizations that don't look like the Latino/Hispanic community has benefited from the pain of the people but don't understand the people
- Address discrimination and colorism within this community
- Uplift the voices of the people instead of coming into communities and trying to save the people

Addressing Racial Divide Among Black and Latino/Hispanic Communities

Addressing HIV among Latino/Hispanic populations means also addressing HIV in Black communities. One of the subject matter experts discussed the "artificial divide that some try to

place between the two populations. For an initiative to work like Ending the HIV Epidemic there must be a united front of “brotherhood and sisterhood.”

Grassroots Organizations

Partnership with grassroots organizations is essential for this work. Participants discussed that a handful of Latino/Hispanic leaders are often called upon to represent the population. Those same leaders are invited to all meetings instead of partnering with organizations that can get deep into the community. Only inviting the same members of leadership is not sustainable because agencies are not invested in building the leadership with the community. “We need to be working with these grassroots organizations to create the tools so that when we leave, we leave communities with this tool so they can carry on with us.” Participants acknowledge that HIV may not be the primary service of any organization in the Latino/Hispanic, but they know how to reach our community. You can fund these agencies and train them on how to deliver HIV services.

Elected Officials Leadership Town Hall

The Elected Officials Leadership Town Hall was held on Tuesday, October 27th, 2020, with two elected officials, Ranking Member of Congress Bennie G. Thompson, Congressman of the 2nd MS Congressional District, Chairman of the Committee on Homeland Security, and John Hines, MS State House of Representative of District 50, along with all partners listed on the flyer to discuss barriers to ending HIV and poor health outcomes in MS. The common theme throughout the town hall was the expansion of Medicaid in and the need for federal elected officials to advocate to ensure that preexisting conditions are covered with expanded coverage through the ACA, especially post the COVID-19 epidemic. Other common themes were that all politics are local, and resources don’t always go where the healthcare needs are greatest. It was concluded that Mississippians must hold their elected officials on all levels accountable for public health responses to all epidemics.



Other Engagement Efforts

On September 10th, the EtHE Initiative held a session in concert with the Transgender and Gender Non-Conforming Education and Advocacy Project (TEAP) MS to plan a Town Hall aimed at engaging members of Mississippi’s transgender and gender non-conforming (TGNC) communities. TEAP MS, a project of the ACLU MS, focuses on strategies that reduce discrimination faced by trans and gender non-conforming people by collaborating directly with the trans community to educate the public-at-large, media, and policymakers. A wide-ranging conversation focused on how the MSDH could work to dismantle anti-transgender and gender non-conforming stigma and biases in communities and in HIV prevention and care and service delivery programs. MSDH posed two large questions to individuals on the call as detailed below.

What can MSDH do to improve health outcomes and decrease the number of Transgender and GNC Mississippians with HIV across the state?

- Education is key for MSDH employees and service providers. TEAP MS offered to partner with the health department and other departments to provide materials directly from the community.

- Clinicians and other providers need additional training on best practices related to providing comprehensive, non-judgmental medical care to TGNC individuals
- Ensure intake protocols and forms used by clinics are sensitive to needs and best practices for TGNC individuals
- Provide signs for funded clinics that affirm respect of all patients as individuals
- Lack of insurance and access to comprehensive health care are significant barriers

What service could MSDH provide?

- Host or refer clinicians to continuing education events
- Work towards expanding the health workforce.
 - Utilize services of AETC and TEAP MS to conduct certification programs demonstrating competency in providing care to TGNC populations.
 - Increase the number of providers completing certification.
 - Think about ways to encourage non-HIV doctors to attend and complete.
 - Create a database of trained providers for TGNC populations to utilize
- Need increased competencies around hormone replacement therapy/affirmation procedures for transwomen
- Other issues affecting the community include homelessness, mental health, and substance use
- Assess barriers for utilizing private insurance for transgender individuals – understanding that private insurance companies do not cover any services related to being TGNC
- Can Ryan White Program begin to cover more services and medications highly utilized by transgender individuals?
- Support legislative and regulatory changes needed to increase access to health care for TGNC Mississippians
- Develop HD needs assessment for TGNC communities in Mississippi
- Improve epidemiology/surveillance data collection for TGNC

Additional conversation focused on the importance of using appropriate language to describe and refer to TGNC Mississippians. Members on the call described the anti-trans bias they have received from medical providers, both in the use of language and assumptions that clinicians and other staff make about individual's lives and health priorities.

The MSDH STD/HIV Office also held a leadership call on September 16, 2020, with the Mississippi Department of Corrections (MDOC) and the MSDH Office of Prevention and Health Equity, which focused on education, training, testing, and expanding services for inmates as they near reentry into the community. MDOC currently does not test inmates prior to release. Current protocols only require testing due to an incident or if requested by medical/health personnel MDOC reentry staff will work with HIV case managers to set up appointments and referrals to medical care and community-based organizations for HIV positive inmates. For those with a negative test result, PrEP counseling and referrals will be offered. The MSDH Office STD/HIV staff also offered to partner with MDOC to provide updated cultural humility and sensitivity training to MDOC staff.

Sexual Health Services: Interviews with providers at HIV and STD clinics

The National Coalition of STD Directors (NCS D) conducted a series of interviews at clinics providing STD testing and treatment to better understand the availability of STD services across the state, the intersection with HIV prevention and treatment services, and to solicit recommendations for the EtHE Plan.

In January 2020, NCS D spoke with three providers to understand what is working well in the delivery of HIV prevention and care services and what challenges must be addressed to meet the goals of ending the HIV epidemic. All three clinics were in Jackson, MS – two in the Jackson Medical Mall. The clinics are aware of the services offered by the other clinics in the area and often refer patients to each other for different services if they are unable to either due to capacity or other reasons. NCS D did not utilize a formal interview guide, however, questions of interest centered on the following themes:

Demographics of clients served

- Funding sources
- Data management/EHR
- Capacity
- Challenges to reaching the HIV community
- Cultural humility
- Barriers to STD testing/treatment
- Linkage to care model

NCS D utilized snowball sampling to identify and interview individuals working in sexual health services representing diversity of geography across Mississippi. Interviews ceased after a saturation point was reached in terms of overlap of themes discerned from conversations. After visiting three initial sites, NCS D met with or had telephone conversations with additional experts and attended a Mississippi HIV Planning Council meeting to receive feedback. Conversations were held with experts at the following locations:

- Open Arms Clinic, Jackson
- Five Point Clinic, Jackson
- Mississippi State Department of Health – Disease Intervention Specialists (DIS)
- AIDS Service Coalition, Hattiesburg
- Meeting of multiple Jackson-based CBOs
- Mississippi HIV Planning Council Meeting, Jackson
- Hattiesburg Family Planning Clinic, Hattiesburg (I also think they talked to Laurel Family Health and to clinics in the delta)
- Individual service provider, Jackson and affiliated with several locations

Specific findings from the NCS D site visits and phone visits are detailed below.

Service Provision/Optimization of Existing Clinic Infrastructure

Sexual health and HIV/AIDS Service Organizations/CBOs throughout Mississippi have leveraged formal and informal partnerships to prioritize client access to services. These relationships exist even among smaller community-based organizations and include private-public partnerships with state health department key personnel such as disease intervention specialists (DIS) and grassroots organizations. Reinforcing these relationships, particularly the informal ones, is crucial to the success of a comprehensive EtHE Plan.

Overall, sexual health providers across Mississippi prioritize representation in staffing/hiring from the community they serve, which helps promote cultural humility in the clinics. Additionally, clinics have innovated to include HIV and STD testing under “general wellness checks” to reduce stigma, include sexual health labs with more traditional primary care labs such as hemoglobin A1C and cholesterol. It is more accessible for patients to come in for a routine “general wellness check” than to come in and request STD or HIV screening. This was identified at the Open Arms clinic where a comprehensive lab panel including STD and HIV testing is offered under the program “Becoming a Healthier You”. Expanding this practice across primary care and even sexual health providers would help increase testing accessibility.

Due to COVID-19, clinics across Mississippi, for example, Express Personal Health, quickly implemented innovative methods, including telehealth visits, more specifically tele-PrEP, to remain connected to and engaged with PrEP patients, particularly students who had to relocate or return home. As a medically underserved area, there is a lack of available sexual health providers, particularly providers where the LGBTQ+ population feels safe receiving services. Consequently, the expansion of telehealth for HIV care through the EHE program would help mitigate the provider gap. However, a related challenge that would have to be addressed is the unstable and inconsistent broadband infrastructure throughout Mississippi, particularly in rural areas. Feedback NCS D received was that it is challenging to even connect via cell phone to order a Lyft or Uber in some areas of Mississippi, for example. There is also an opportunity for public health to partner with telecom companies around increasing broadband access in medically underserved areas across the state.

Another innovation that has evolved out of the COVID-19 epidemic is the onset of self-collect STD testing, which involves dispensing or mailing STD testing kits for individuals to self-collect samples and then mail them back to a local lab. Several health departments across the country are creating home-grown at-home testing solutions, but there are contracting options available as well. Self-collection could increase STD, and even HIV, testing overall as well as support PrEP follow-up lab testing. The MS EtHE Initiative is exploring home testing options. Currently, there is significant community outreach occurring across Mississippi around HIV rapid testing, particularly by smaller CBOs with mobile vans like My Brother’s Keeper and CARE4ME Services. Expanding rapid HIV testing will be important to end the HIV epidemic, particularly in areas with transient populations such as in the Mississippi Delta. Expanding rapid HIV testing must also include expanding staff capacity to conduct HIV testing and ensure linkage to care and follow-up testing, as necessary.

FQHCs, primary care providers as well as traditional sexual health providers including STD clinics, ASOs, and CBOs would benefit from the implementation of regular comfort surveying with their clients. This would involve a random sample of clients served by the clinic and ask brief, measurable questions about the client’s experience at the clinic including how safe they felt during

their visit, how respected they felt by staff, and what steps could be taken to improve clients' comfort.

Cultural humility was mentioned as a deficit among most individuals and organizations interviewed for this project because staff automatically think the training is "not for people like them" and are thus dismissive of them. Instead of treating cultural humility as a one-off, such as one webinar or meeting per year, organizations should include [it] in their strategic plans and make a constant effort to measure their progress and evolve as an organization in this vein. The comfort survey is a good tool to measure the extent to which cultural humility is observed by clients.

A challenge across clinics appears to be data management and electronic health record (EHR) management. Many clinics have created labor-intensive workarounds to EHRs that are not sufficiently optimized including double-entering data into other data management systems such as REDCap. EHR optimization should become a priority to streamline data for the EHE program. Users of the same EHR can form informal technical support groups to exchange best practices and join existing, national groups of sexual health clinics that use a particular EHR.

Support Services

Bolstering support services is crucial to improving sexual health care which plays a critical role in ending the HIV epidemic. This is a challenge that was noted by several CBOs as well as by the MHPC. Transportation continues to be a barrier to getting and keeping individuals in care. It is crucial that sufficient funding be allotted to support transportation. Presently, no blanket transportation solution for all of Mississippi exists; instead, CBOs and ASOs should be allowed flexibility to select a solution that serves the needs of their population. For example, as previously noted, rideshare services such as Uber and Lyft are not currently available throughout Mississippi. The MS EtHE initiative is currently working with MDOT and other partners to address gaps in transportation servicing to ensure PWH and individuals at risk for acquiring STD/HIV know their status and stay in care.

Additionally, targeted efforts toward retention of patients in HIV care should be enhanced, like the Data to Care model. Retention is often rooted in successful, personal one-on-one relationships with patients and addressing the social determinants of health, which cannot be accomplished while short-staffed; consequently, adequate resources must be allotted to support keeping patients in care.

Public Health Information/Training/Professional Development

The lack of sexual health education particularly in schools was cited as a significant challenge across stakeholders. Consequently, community networking around public health information could play an important role in decreasing stigma and providing a baseline understanding of sexual health overall and HIV prevention. Additionally, NCSd received feedback that PrEP ad campaigns on television and social media are primarily geared toward Black men who have sex with men (MSM), which sends the message that only this group of individuals are susceptible to HIV. Expanding messaging to target other higher-risk groups such as Black women and college students/young adults would help to increase HIV awareness overall.

Professional development opportunities around sexual health, including the diagnosis and

treatment of STDs and HIV, would fill a critical gap in training among medical providers across Mississippi and address confusion about syphilis treatment guidelines. Peer to peer learning models can be developed that teach master trainers (medical providers themselves) to go out into the community and train other providers. In this model, physician assistants would train other physician assistants, nurse practitioners would train other nurse practitioners, and so on. This model could also be implemented to provide cultural humility training and rapid-start ART initiation.

Recommendations

- Enhance, formalize, and incentivize existing partnerships among community-based organizations, FQHCs, and other clinics to prioritize client access, reduce stigma and provide wrap-around services/continuity of care
- Expand tele-PrEP and telehealth as it relates to HIV care while addressing broadband bandwidth issues
- Implement self-collect STD testing
- Expand HIV testing as well as associated linkage to care staff
- Implement regular comfort surveys at clinics providing sexual health services and ensure clinics implement feedback
- Support data management and EHR optimization
- Significantly increase transportation budgets
- Enhance targeted efforts toward retention in HIV care
- Community networking around public health information
- Expand intended audience for PrEP/PEP messaging

Appendix D – BAI Interview Guide

In-Depth Interviews

Spring 2020

Background information

The goal of this project is to hear from various communities around Mississippi about their knowledge and understanding of Ending the Epidemic principles and practices in Mississippi. Over the course of this project, the Mississippi State Department of Health hopes to speak to community members in different parts of the state, focusing on Black communities, those who provide care in Black communities, and other stakeholders. The project will begin in Greenville and Laurel, Mississippi with in-depth interviews, followed by in-depth interviews and a town hall.

Objectives

The overarching research questions are:

1. How do the intended audiences understand efforts to end the HIV epidemic in their state and smaller communities? Where does this knowledge come from?
2. What are the experiences of intended audiences with HIV education, testing, prevention, and treatment?
3. How do the intended audiences experience stigma surround HIV, race, gender identity, and ethnicity? What factors reinforce or reduce that stigma?
4. How do the intended audiences experience policy relate to HIV, race, gender identity, and ethnicity? What factors reinforce or reduce that stigma?
5. How do the intended audiences make decisions about HIV prevention, care, and treatment? What reinforces making informed decisions and what serves as barriers or obstacles to making decisions that people feel work best for them?
6. What are the intended audiences' experiences, feelings, about social media campaigns related to HIV services? Any recommendations on how to reach and mobilize the community?

Note to Facilitator:

- *Information in italics signifies script for the facilitator*
- {Information underlined and in brackets indicates directions for the facilitator}

In dept Interview

- ✓ Background notes on interviewee
- ✓ Demographic questionnaire,
- ✓ Recorder and extra batteries, or capability to record the call
- ✓ Incentives and receipt forms, one per participant recruited
- ✓ Consent forms, two copies for each participant (one to sign and one to keep) plus extras

Outline with Timing

Minutes per section	Topic	Elapsed time at end of section (minutes)
5	Welcome and introductions	5
5	Obtain informed consent and confirm compensation	10
15	Ask demographic questionnaire	25
10	Existing attitudes and beliefs about HIV	35
15	HIV Risk and Knowledge-Seeking	50
10	Awareness of ending the epidemic campaigns	60
5	Dissemination of Information	65
5	Additional information shared by participants	70
5	Closing	75

Introduction

(5 min)

Welcome – Explain purpose of the in-depth interview

- *Thank you for agreeing to participate in this in-depth interview. My name is [NAME], and I am the facilitator for our conversation. It is a pleasure to be with you today. I know your time is valuable and we appreciate you sharing your opinions with us. Your opinions and experiences will help us develop programs that will help others learn more about Mississippi's efforts to end the HIV epidemic.*
- *I will be recording and typing during our session.*
- *I would like to talk to you about HIV prevention, treatment, testing, and the Ending the Epidemic plan in Mississippi. We want to hear your opinions and experiences with health care related to HIV services This project is funded by the Mississippi State Department of Health and your opinions and experiences will help them develop campaigns and help guide their HIV-related services. We understand that discussing HIV can be a sensitive topic to talk about, so if you would rather not answer a question, you don't have to answer it.*

- *I want to make it clear that we are not asking you to share specific information about any medical issues that you may have. We also don't want you to name or identify other individuals who may face any medical issues.*
- *Speaking of privacy, as I mentioned, I am audio taping the discussion so that we can take good notes. But when we write reports about what we learned, we will not use your name or connect you with anything that you say. Only the people involved in facilitating and taking notes will have access to the recordings, and we will also delete the recordings as soon as our notes are finalized.*
- *This discussion will last about an hour and fifteen minutes.*

Obtain Informed Consent

(10 min)

{As participants arrive, have them read and sign the informed consent form. Give each person an unsigned copy of the form to keep.}

At the start of the in-depth interview, the facilitator will remind the participant about confidentiality and ask if they agree to participate in a recorded (video/audio) in-depth interview

- *We've emailed you a consent form, and you sent back a signed copy. Do you have any questions?*

Demographic Questions

(5 minutes)

To get started, let's go around and introduce ourselves. As a way of getting to know each other, please tell us the name you will be using today and the first word that comes to mind when you think about visiting a doctor.

{FACILITATOR: Complete introductions.}

Thank you. It is nice to meet all of you. Each of your voices is important and we look forward to hearing from you all.

Existing Attitudes and Beliefs (10 min)

1. How is HIV viewed or perceived in Mississippi? (What do people think about HIV?)
 - a. Tell me more about that.
 - Does it change depending on what part of Mississippi you're in?
 1. If so, how?
 2. How is it viewed or perceived particularly in your community?

- Why might some people say that HIV is a problem, challenge, or issue in Mississippi?
 1. What about in your community?
 - Why might some people say that HIV is not a problem, challenge, or issue in Mississippi?
 1. What about in your community?
 - What can be done to get past those barriers/challenges?
2. Community attitudes toward existing HIV education and testing
 - a. How do Black people/ Black men/Black women feel about their access to HIV educational materials or campaigns?
 - b. How do Black people/ Black men/Black women feel about their access to HIV testing?
 - c. Where are the best places to receive support and access to HIV education and testing?
 - d. What are some of the things that get in the way of accessing HIV education and testing?
 - e. What can be done to get past those barriers/challenges?
 3. Community attitudes toward existing HIV care services
 - a. How do members of the Black community/ Black men/ Black women feel about the state of HIV care and treatment?
 - b. Where are the best places to receive HIV care?
 - c. What are some of the things that get in the way of receiving HIV care?
 - d. What can be done to get past those barriers/challenges?
 4. Community attitudes toward existing efforts to end the HIV epidemic
 - a. Do you feel like members of the Black community are aware of the national plan to end the HIV epidemic?
 - i. Do they know that Mississippi is listed as one of the 7 high priority states?
 - ii. How do you think this affects what people expect of their government?
 - b. How do members of the Black community feel about the state of HIV care and treatment?
 - c. What are some of the things that get in the way of ending the HIV epidemic in Mississippi?
 - i. In your community?
 - d. What can be done to get past those barriers/challenges?
 5. Community experiences of discrimination
 - a. How do you feel racism affects access to HIV care and prevention services for the Black community?
 - b. How do you feel discrimination impacts access to HIV care and prevention services for the Black community?
 6. What is stigma?
 - a. Do you think stigma impacts efforts to end the HIV epidemic in Mississippi?
 - b. Give an example of community stigma
 - c. Give an example of internal stigma
 - d. What are some recommendations you have to address stigma?

-
7. Knowledge and attitudes toward biomedical and technological interventions
 - a. HIV self-testing
 - i. How many people in the Black community know that you can get an HIV test over the counter that you can take home and test yourself? How many have used it? How many are willing to use it?
 - ii. What are the benefits/downsides of self-testing? What would increase use? Decrease use?
 - iii. What would a person do if they got a positive home test result?
 - b. Pre-Exposure Prophylaxis (PrEP)
 - i. How many people in the Black community know that you can take medicine (called PrEP) every day to keep from getting HIV? Where can Black people get PrEP?
 - ii. What have you heard about PrEP in the Black community?
 - iii. What are the benefits/downsides of PrEP?
 - iv. What are some things that get in the way of using PrEP?
 - v. What would make it more likely that people of the Black community would use it?
 - c. Post-exposure prophylaxis (PEP)
 - i. How many people in the Black community know that you can take medicine (called PEP) within 72 hours after potential exposure to HIV to prevent infection? Where can people in the Black community get PEP?
 - ii. What have you heard about PEP in the Black community?
 - iii. What are the benefits/downsides of PEP?
 - iv. What are some things that get in the way of using PEP?
 - v. What would make it more likely that people in the Black community would use it?
 - d. Treatment as Prevention/U=U
 - i. How many people in the Black community know that PLHIV who are on medicine that keeps their virus undetectable for a sustained period have virtually no risk of passing HIV to their sexual partners?
 - ii. What have you heard about U=U or treatment as prevention?
 - iii. Would people in the Black community willing to start HIV treatment as soon as they tested positive to prevent passing HIV to their partners? If not, why not?
 8. What are some barriers to Black people starting HIV treatment as soon as possible? What do you think of when you hear the phrase “Ending the Epidemic”?
 - e. What are some things people can do to prevent HIV?
 - f. What do you think keeps people from using these prevention measures?
 - g. What can state and local governments do to end the epidemic?
 - h. Are there any people or organizations in your community that you would consider leaders on Ending the Epidemic? What makes them leaders?

9. How did you learn what you know about HIV?
 - a. When did you first learn about it?
 - i. How has that changed over time?
 - ii. Have you learned more about HIV since the first time you learned about it?
 - b. Is there any person or organization in your community that you would consider a leader on HIV education? What makes them a leader?

Awareness of Ending the Epidemic Campaigns (10 min)

10. What is the best messaging approach/things to remember when explaining Ending the Epidemic initiatives to Black people?
11. Have you ever seen any social media posts or billboards or anything like that about HIV?

IF YES:

- i. Can you tell me about them?
- j. What did you think about them?
- k. How did they make you feel?

IF NO:

- a. What would you like to see in the media about HIV?

Dissemination of Information(5 min)

1. I want to know about your preferences, likes and dislikes when it comes to getting information about HIV.
 - a. How would you like to get information about HIV?
 - b. Where would you like to get information about HIV?
 - c. Who would you like to see this information come from?
2. What kind of information do you need to help you prevent HIV and get healthcare related to preventing?
 - a. What about privacy, would you feel comfortable receiving that information in a public place?
 - b. Would you grab informational material if it were out on a table or desk somewhere?
 - c. Would you comment on it or “like” it if it were on social media?
 - d. Anything else we should consider?

Other Information Provided [intended audience] (5 min)

Thank you for your time and participation in this group discussion. You have answered many questions and shared your experiences with us, and we really appreciate it. The information that you provided will be used to provide information and messages to people so that they may be more informed about HIV prevention.

1. Is there anything else that you would like to add about any of the topics that we've discussed today?
2. Are there other topics related to preventing HIV that we didn't discuss that you think are important?
3. Are there people or organizations you think we should speak to?
4. We are thinking about ways to get community input remotely, due to COVID-19. If we were to host a zoom call or Facebook townhall, do you think people in your community would be interested? Do you think they would be able to join?

Closing (5 min)

Again, thank you. We know this is not an easy topic. If you have any questions about this group discussion, you can reach out using the contact information on the handout you received before we started.

Appendix E - BAI Focus Group Materials

Virtual Focus Group Run of Show

Location: Zoom

Minutes per section	Topic	Elapsed time at end of section (minutes)
5	Welcome and introductions- discuss muting individuals	5
5	Obtain informed consent and confirm compensation	10
15	Existing attitudes and beliefs about HIV	30
15	HIV Risk and Knowledge-Seeking	45
15	Awareness of ending the epidemic campaigns	60
10	Dissemination of Information	70
10	Additional information shared by participants	80
5	Closing	85

Introduction

(5 min)

Welcome – Explain purpose of the focus group

- *Thank you for agreeing to participate in this in-depth interview. My name is Leisha, and I am the facilitator for our conversation. It is a pleasure to be with you today. I know your time is valuable and we appreciate you sharing your opinions with us. Your opinions and experiences will help us develop programs that will help others learn more about Mississippi's efforts to end the HIV epidemic.*
- *Fatima will be recording and typing during our session.*
- *I would like to talk to you about HIV prevention, treatment, testing, and the Ending the Epidemic plan in Mississippi. We want to hear your opinions and experiences with health care related to HIV services. This project is funded by the Mississippi State Department of Health and your opinions and experiences will help them develop campaigns and help guide their HIV-related services. We understand that discussing HIV can be a sensitive topic to talk about, so if you would rather not answer a question, you don't have to answer it.*
- *I want to make it clear that we are not asking you to share specific information about any medical issues that you may have. We also don't want you to name or identify other individuals who may face any medical issues.*
- *Speaking of privacy, as I mentioned, I am audio taping the discussion so that we can take good notes. But when we write reports about what we learned, we will not use your name or connect you with anything that you say. Only the people involved in facilitating and taking notes will have access to the recordings, and we will also delete the recordings as soon as our notes are finalized.*

- *This discussion will last about an hour and a half*

Obtain Informed Consent

(10 min)

{As participants arrive, have them read and sign the informed consent form. Give each person an unsigned copy of the form to keep.}

At the start of the focus group, the facilitator will remind participants about confidentiality and ask if they agree to participate in a recorded (video/audio) focus group.

- *In front of you, there are two sheets of paper. This is our consent form. One is for you to sign and leave here, and the other one is for you to keep.*
- *We will give you a few minutes to read through the form, sign, and date it. Please feel free to ask us any questions before you sign. We will also go over it in 5 minutes and will answer any additional questions you may have.*
- {Give participants 5 minutes to read the document. Answer any questions participants have currently.}
- *I'd like to go over this form briefly as a group.*
 - o *Purpose:* *We are talking with groups of people from different communities around the county to discuss and learn their opinions about HIV services. We want to hear your opinions and learn about your experiences with health care related to preventing HIV.*
 - o *Risks:* *There are no specific risks to participating in this discussion.*
 - o *Benefits:* *There are no direct benefits, but your participation will help develop some ways that information about HIV services is shared with Mecklenburg Department of Health and the public.*
 - o *Do you have any questions?*

Ground rules

-
- *We want to start by saying that this is a safe space. We value your opinions and your experiences. We want to give everyone an opportunity to speak.*
 - *Before we continue, I would like to go over some ground rules for our discussion today.*
 - {Facilitators note: put the ground rules in the zoom chat box}
 - *We **want to hear from everyone here**. This works best if I speak very little while you do most of the talking.*
 - *You **don't need to raise your hand or wait for me to call on you** before you speak.*

- *Let's try to make sure only **one person speaks at a time**, so everyone is heard.*
- *Also, because we're recording, **please try to speak in a voice at least as loud** as the one I'm using now so that we can hear everyone on the tape.*
- *We want your honest opinions and reactions. There are **no right or wrong answers**. Feel free to disagree or express a different opinion.*
- *We'll be here for an hour and a half and we're not going to take any formal breaks so feel free to step out if you need to use the restroom. It is located **{location of bathroom}**.*
- *Please **do not discuss the focus group topics outside** of the room.*
- *Last little reminder, please **mute yourself if you are not talking***
- *Are there other ground rules you would like to*

add? Great, a few reminders:

- *At any time during our conversation, let me know if you have any questions or if you would rather not answer a specific question.*
- *We'll be taking notes on our conversation, but just to make sure that our notes are complete, we will be recording our conversation.*
 - *Is it OK with all of you that we record this discussion?*
 - {IF YES: proceed to record}
 - {IF NO: If one person does not agree to be recorded, do not record the focus group, and pay closer attention during notetaking. Facilitator may need to repeat and verbally summarize general comments at end of each section. Also, write down as much you can on flip charts, if it does not disrupt the flow of the conversation.}

{Create pseudonyms and name tags}

- *As mentioned earlier, to make sure this conversation stays anonymous, we want each of you to create a name. We can use this name to refer to you throughout our time together.*
- *Thank you. Does anyone have questions before we begin?*

{Turn on zoom recorder.}

Warm-up (5 minutes)

To get started, let's go around and introduce ourselves. As a way of getting to know each other, please tell us the name you will be using today and the first word that comes to mind when you think about visiting a doctor.

{FACILITATOR: Complete introductions.}

Thank you. It is nice to meet all of you. Each of your voices is important and we look forward to hearing from you all.

Existing Attitudes and Beliefs (15 min)

1. How is HIV viewed or perceived in Mississippi? (What do people think about HIV?)
 - b. Tell me more about that.
 - Does it change depending on what part of Mississippi you're in?
 1. If so, how?
 2. How is it viewed or perceived particularly in your community?
 - Why might some people say that HIV is a problem, challenge, or issue in Mississippi?
 1. What about in your community?
 - Why might some people say that HIV is not a problem, challenge, or issue in Mississippi?
 1. What about in your community?
 - What can be done to get past those barriers/challenges?
2. Community attitudes toward existing HIV education and testing
 - a. How do Black people/ Black men/Black women feel about their access to HIV educational materials or campaigns?
 - b. How do Black people/ Black men/Black women feel about their access to HIV testing?
 - c. Where are the best places to receive support and access to HIV education and testing?
 - d. What are some of the things that get in the way of accessing HIV education and testing?
 - e. What can be done to get past those barriers/challenges?
3. Community attitudes toward existing HIV care services
 - a. How do members of the Black community/ Black men/ Black women feel about the state of HIV care and treatment?
 - b. Where are the best places to receive HIV care?
 - c. What are some of the things that get in the way of receiving HIV care?
 - d. What can be done to get past those barriers/challenges?
4. Community attitudes toward existing efforts to end the HIV epidemic
 - a. Do you feel like members of the Black community are aware of the national plan to end the HIV epidemic?
 - i. Do they know that Mississippi is listed as one of the 7 high priority states?
 - ii. How do you think this affects what people expect of their government?

- b. How do members of the Black community feel about the state of HIV care and treatment?
- c. What are some of the things that get in the way of ending the HIV epidemic in Mississippi?
 - i. In your community?
- d. What can be done to get past those barriers/challenges?
- 5. Community experiences of discrimination
 - a. How do you feel racism affects access to HIV care and prevention services for the Black community?
 - b. How do you feel discrimination impacts access to HIV care and prevention services for the Black community?
- 6. What is stigma?
 - e. Do you think stigma impacts efforts to end the HIV epidemic in Mississippi?
 - f. Give an example of community stigma
 - g. Give an example of internal stigma
 - h. What are some recommendations you have to address stigma?

HIV Risk and Knowledge-Seeking

(15 min)

-
- 7. Knowledge and attitudes toward biomedical and technological interventions
 - l. HIV self-testing
 - i. How many people in the Black community know that you can get an HIV test over the counter that you can take home and test yourself? How many have used it? How many are willing to use it?
 - ii. What are the benefits/downsides of self-testing? What would increase use? Decrease use?
 - iii. What would a person do if they got a positive home test result?
 - m. Pre-Expose Prophylaxis (PrEP)
 - i. How many people in the Black community know that you can take medicine (called PrEP) every day to keep from getting HIV? Where can Black people get PrEP?
 - ii. What have you heard about PrEP in the Black community?
 - iii. What are the benefits/downsides of PrEP?
 - iv. What are some things that get in the way of using PrEP?
 - v. What would make it more likely that people of the Black community would use it?
 - n. Post-exposure prophylaxis (PEP)
 - i. How many people in the Black community know that you can take medicine (called PEP) within 72 hours after potential exposure to HIV to prevent infection? Where can people in the Black community get PEP?
 - ii. What have you heard about PEP in the Black community?
 - iii. What are the benefits/downsides of PEP?
 - iv. What are some things that get in the way of using PEP?

- v. What would make it more likely that people in the Black community would use it?
- o. Treatment as Prevention/U=U
 - i. How many people in the Black community know that PLHIV who are on medicine that keeps their virus undetectable for a sustained period have virtually no risk of passing HIV to their sexual partners
 - ii. What have you heard about U=U or treatment as prevention?
 - iii. Would people in the Black community willing to start HIV treatment as soon as they tested positive to prevent passing HIV to their partners? If not, why not?
 - 1. What are some barriers to Black people starting HIV treatment as soon as possible?
- 8. What do you think of when you hear the phrase “Ending the Epidemic”?
 - p. What are some things people can do to prevent HIV?
 - q. What do you think keeps people from using these prevention measures?
 - r. What can state and local governments do to end the epidemic?
 - s. Are there any people or organizations in your community that you would consider leaders on Ending the Epidemic? What makes them leaders?
- 9. How did you learn what you know about HIV?
 - b. When did you first learn about it?
 - i. How has that changed over time?
 - ii. Have you learned more about HIV since the first time you learned about it?
 - c. Is there any person or organization in your community that you would consider a leader on HIV education? What makes them a leader?

Awareness of Ending the Epidemic Campaigns

(10 min)

-
- 10. What is the best messaging approach/things to remember when explaining Ending the Epidemic initiatives to Black people?
 - 11. Have you ever seen any social media posts or billboards or anything like that about HIV?

IF YES:

- t. Can you tell me about them?
- u. What did you think about them?
- v. How did they make you feel?

IF NO:

- b. What would you like to see in the media about HIV?

Dissemination of Information (5 min)

1. I want to know about your preferences, likes and dislikes when it comes to getting information about HIV.
 - a. How would you like to get information about HIV?
 - b. Where would you like to get information about HIV?
 - c. Who would you like to see this information come from?
2. What kind of information do you need to help you prevent HIV and get healthcare related to preventing?
 - a. What about privacy, would you feel comfortable receiving that information in a public place?
 - b. Would you grab informational material if it were out on a table or desk somewhere?
 - c. Would you comment on it or “like” it if it were on social media?
 - d. Anything else we should consider?

Dissemination of Information(5 min)

3. I want to know about your preferences, likes and dislikes when it comes to getting information about HIV.
 - a. How would you like to get information about HIV?
 - b. Where would you like to get information about HIV?
 - c. Who would you like to see this information come from?
4. What kind of information do you need to help you prevent HIV and get healthcare related to preventing?
 - a. What about privacy, would you feel comfortable receiving that information in a public place?
 - b. Would you grab informational material if it were out on a table or desk somewhere?
 - c. Would you comment on it or “like” it if it were on social media?
 - d. Anything else we should consider?

Other Information Provided [intended audience] (10 min)

Thank you for your time and participation in this group discussion. You have answered many questions and shared your experiences with us, and we really appreciate it. The information that you provided will be used to provide information and messages to people so that they may be more informed about HIV prevention.

1. Is there anything else that you would like to add about any of the topics that we've discussed today?
2. Are there other topics related to preventing HIV that we didn't discuss that you think are important?

Are there people or organizations you think we should speak to?
3. We are thinking about ways to get community input remotely, due to COVID-19. If we were to host a zoom call or Facebook townhall, do you think people in your community would be interested? Do you think they would be able to join?

Closing (5 min)

Again, thank you. We know this is not an easy topic. If you have any questions about this group discussion, you can reach out using the contact information you have for us.

Virtual Focus Group Run of Show

Location: Zoom

Time	Activity
4:30 pm CST	Last social media push- tell people to post/DM/email their questions about EHE in Greenville for the town hall
5:00 pm CST	Panelists/Speakers join the zoom call, any technical issues are addressed
5:30 pm CST	Open the zoom room. Cameras and mics will be automatically off.
5:35 pm CST	<p>Introductions and housekeeping:</p> <ul style="list-style-type: none"> - We will be muted - The town hall will be recorded - Asking that people conduct themselves as they would at an in-person town hall - Remind people that polls will be taken but there will not be identifiable information - Remind people that the town hall will inform the EHE plan - After each section we will take questions from the question box as well as from social media
5:40 PM CST	Start with first poll (see below)
5:45 pm CST	<p>So, what is EHE?</p> <p>Leisha gives national context of EHE</p> <p>Deliverable:</p> <ul style="list-style-type: none"> . Discussion of PrEP and nPEP and how they are used as medical interventions c. Discuss the benefits of being retained in HIV care d. Discuss the benefits of medication adherence. <ul style="list-style-type: none"> i. Viral Suppression ii. U=U (undetectable=untransmittable) model <p>Henry Fuller gives state context</p> <p>Maxx gives context of BAI WTP plan</p> <p>Deliverable:</p> <ul style="list-style-type: none"> BAI will discuss community-level interventions in communities of color <ul style="list-style-type: none"> i. Community mobilization ii. Community advocacy
6:00 pm CST	<p>Community question: How do you feel HIV affects your community?</p> <p>Read out responses from the chat box. If less than 50 people, allow to unmute</p> <p>Deliverable:</p> <ul style="list-style-type: none"> iii. Frame community needs

	iv. How to present, "The Ask"
6:10 pm CST	Community question: What organizations do you think need to be involved in EHE plans? Read out responses from the chat box. If less than 50 people, allow to unmute
6:20 pm CST	Local Discussion of EHE- Dr. Mauda Monger, Linda M. Dixon, and Dr. Christopher Roby
	Administer second poll while panelists speak
6:30 pm CST	Community question: How can the government support the Black community through EHE? How can we support each other during COVID-19? Deliverable: a. Strategies to prevent new HIV/STD infections among Blacks and Latinos/Latinx, including HIV/STD testing
6:50 pm	Reiterate next steps: The report will be used by the state government. Once it's compiled, you will be able to access it at---. You can access the whole WTP report at blackaids.org
7:00 pm	Closing and thank you
	Last poll

Poll 1 At the Beginning

Q1. How old are you?

I am _____ years old

Q2. What is your gender?

Please specify: _____

Q3. What is your sexual orientation?

Please specify: _____

Q4. What is your relationship status?

- Married, or in a domestic partnership
 - In a committed relationship
 - Widowed Divorced
 - Separated Never married
-

Q5. What is your race? (Mark one or more boxes)

Please specify _____

Q6. Are you of Hispanic or Latino origin?

No; not of Hispanic or Latino origin

Yes, Mexican, Mexican American, Chicano

Yes, Puerto Rican

Yes, Cuban

Yes, another Hispanic or Latino origin. Please specify, for example: Colombian, Salvadoran, etc. _____

Q7. Please tell us your city/town/neighborhood:

Poll 2

What HIV resources are you familiar with in your community?

Poll 3

Do you want to get updates on Mississippi's EHE plans?

Updates on BAI's work?

If so, what is your email:

Appendix F – Additional Sample Meeting Agendas

Elected Officials Leadership Town Hall Agenda

1. Welcome and Introduction by Mississippi Department of Health
2. Introduction of National Organizer/Moderator
3. Audience Poll
4. Call to Action
5. Panelists Introduction
6. Community Sharing of Truth/Testimonials
7. Panel Discussion with Elected Official Panelists - Bennie Thompson, John W. Hines Sr, and other Community Panelist
8. Open Floor for Discussion and Q&A
9. Audience Poll
10. Next Steps
11. Adjourn

Black Women Leadership Meeting

AGENDA

*MS EHE Task Force - Mississippians Who are Black Women Focused Leadership Consultation and Town Hall Planning Meeting
Thursday, October 29th, 2020
6:00 p.m. (CST)*

Audience: Black Women/Women of Color Leaders Concerned About the Health and Well-Being of Black Women/Women of Color and HIV in Black Women/Women of Color

- I. Welcome
- II. Introductions
- III. Call to Action
- IV. Summary of MS EHE Initiative
- V. MS EHE Jurisdictional Plan
- VI. Purpose of the MS HIV Planning Council and the MS EHE Task Force
- VII. Open Floor for Discussion
- VIII. Next Steps
- IX. Closing Remarks
- X. Adjourn

AGENDA

MS Ending the HIV Epidemic (EtHE) CHC Partnership Consultation Meeting
Friday, October 30th, 2020, 9:00 a.m. (CST)

- I. Welcome
- II. Introductions
- III. Summary of MS EHE Initiative
- IV. MS EHE Jurisdictional Plan
- V. Purpose of Accountability to the MS HIV Planning Council and the MS EHE Task Force
- VI. Purpose of Partnership
- VII. Open Floor for Discussion
- VIII. Next Steps
- IX. Closing Remarks
- X. Adjourn

AGENDA

MS Ending the HIV Epidemic (EtHE) CBO Partnership Consultation Meeting
Friday, October 30th, 2020, 10:00 a.m. (CST)

- I. Welcome
- II. Introductions
- III. Summary of MS EHE Initiative
- IV. MS EHE Jurisdictional Plan
- V. Purpose of Accountability to the MS HIV Planning Council and the MS EHE Task Force
- VI. Purpose of Partnership
- VII. Open Floor for Discussion
- VIII. Next Steps
- IX. Closing Remarks
- X. Adjourn

AGENDA

MS Ending the HIV Epidemic (EtHE) Task Force Meeting
Friday, October 30th, 2020, 1:00 p.m. (CST)

- I. Welcome
- II. Introductions
- III. Summary of MS EHE Initiative
- IV. MS EHE Jurisdictional Plan
- V. Purpose of Accountability to the MS HIV Planning Council and the MS EHE Task Force
- VI. Purpose of Partnership
- VII. Open Floor for Discussion
- VIII. Next Steps
- IX. Closing Remarks