MISSISSIPPI STATE DEPARTMENT OF HEALTH

2017-2021
Statewide Coordinated Statement of Need

September 2016

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ACRONYMS

ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AEH	Aaron E. Henry Community Health Services Center
ART	Antiretroviral Treatment
ARV	Antiretroviral (used synonymously with ART)
ASO	AIDS Service Organization
BRFSS	Behavioral Risk Factor Surveillance Survey
CBDPP	Community-Based Dental Partnership Program
CBO	Community-Based Organization
CDC	Centers for Disease Control
C&T	Counseling and Testing
DIS	Disease Intervention Specialist
DX	Diagnosis
ED	Emergency Department
eHARS	Enhanced HIV/AIDS Reporting System
EIS	Early Intervention Services
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GACFHC	G.A. Carmichael Family Health Center
HAB	HIV/AIDS Bureau
HCC	HIV/AIDS Care Continuum
HEI	HIV Early Intervention
HERR	Health Education/Risk Reduction
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HOPWA	Housing Opportunities for Persons with AIDS
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IDU	Intravenous drug user
LGBTQ	Lesbian, Gay, Bi-Sexual, Transgender, Queer or Questioning (also referred to as Gender and Sexual Minorities by the Centers for Medicare and Medicaid)
MDOC	Mississippi Department of Corrections
MHMR	Mental Health Mental Retardation
MMP	Medical Monitoring Program
MSA	Metropolitan Statistical Area
MSDH	Mississippi State Department of Health
MSM	Men having sex with men
MSU	Mississippi State University
NHAS	National HIV/AIDS Strategy
NHBS	National HIV Behavioral Surveillance System
NHSC	National Health Services Corp.
OMS	Oral Maxillofacial Surgery
OSAR	Outreach, Screening, Assessment and Referral

ACRONYMS (continued)

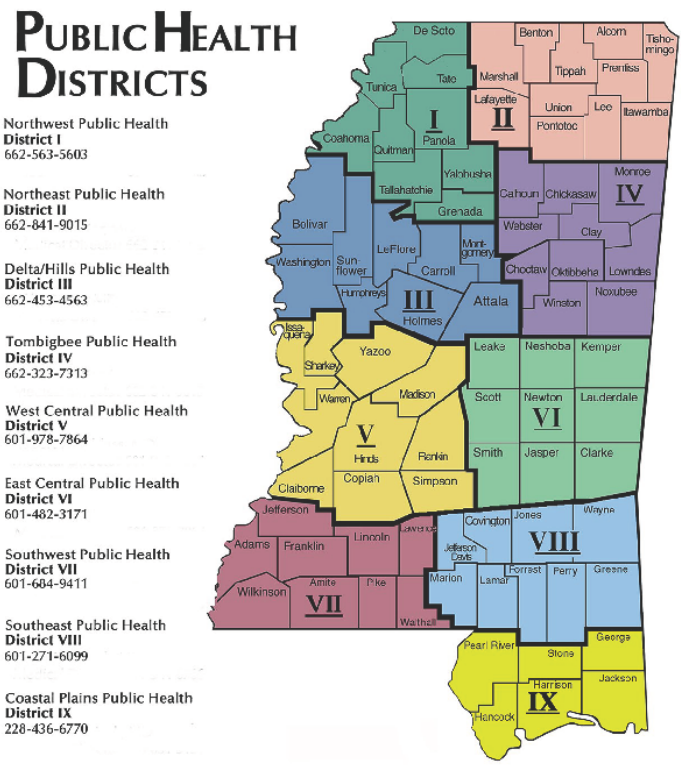
PCP	Primary Care Doctor/Practitioner
PHI	Patient Health Information
PLWH	People/Person(s) Living with HIV or AIDS
PrEP	Pre-Exposure HIV Prophylaxis
PTSD	Post-Traumatic Stress Disorder
RWHAP	Ryan White HIV/AIDS Program
SAMISS	Substance Abuse and Mental Illness Symptoms Screener
SAMHSA	Substance Abuse and Mental Health Services Administration
SeMRHI	Southeast Mississippi Rural Health Initiative, Inc.
SNAP	Supplemental Nutrition Assistance Program
STD or STI	Sexually Transmitted Disease or Sexually Transmitted Infection
STRMU	Short-Term Rent, Mortgage and Utility Assistance
TBRA	Tenant-Based Rental Assistance
UMMC	University of Mississippi Medical Center
WIC	Women, Infants and Children
YRBSS	Youth Risk Behavioral Surveillance Risk Factor

EXECUTIVE SUMMARY

The 2017-2021 Integrated HIV Statewide Coordination Statement of Need/Prevention & Care Plan was designed to fulfill Federal Guidelines of the Ryan White HIV/AIDS Program (RWHAP) and provide critical information to help accelerate progress toward reaching the goals of the National HIV/AIDS Strategy (NHAS). This strategy aims to prevent new HIV infections, increase access to care, improve health outcomes, and reduce HIV-related disparities.

- The State of Mississippi, located at the southern tier of the United States, borders Alabama to the east, Louisiana and Arkansas to the west and the Gulf of Mexico at the south.
- The 2014 population is estimated at 2,984,345, slightly less than 1% of the U.S. population.[1] The State is 49% male, 20% between age 20-34 (the age most at risk for HIV), 58% White, non-Hispanic, 37% Black, non-Hispanic, and relatively young with a median age of 36.3 years compared to 37.4 nation-wide.
- In the State, 18% are without a high school diploma, and 23% are living below the Federal Poverty Level (FPL). This compares poorly to national averages where 14% did not complete high school and 16% were below FPL.
- Mississippi is divided into nine health districts (District) with populations ranging from 173,000 in District 7 to 638,862 in District 5.

Figure ES.1
State of Mississippi Public Health Districts



- The Jackson Metropolitan Statistical Area (MSA) which includes five counties (Copiah, Hinds, Madison, Rankin and Simpson) was identified by the Centers for Disease Control (CDC) as the epi-center of HIV in Mississippi.

[1] U.S. Census Bureau American Community Survey 2014 Five Year Estimates. All population statistics are from this source. See also Jacob S. Hacher and Paul Pierson, Analysis based on data from the Census Bureau, Bureau of Economic Analysis, etc., The New York Times, July 31, 2016.

REGIONAL EPIDEMIC

As of December 31, 2014, 15,580 cases of HIV/AIDS have been reported in the State of Mississippi. Of these, 9,456 are living with the disease (PLWH). In 2014, 484 persons were newly diagnosed.

The profile of HIV/AIDS weighs heavily on males, young adults, Blacks, and men who have sex with men (MSM).

- Males are more than two-thirds of all new diagnoses and persons living with HIV/AIDS. In 2014, 77% of all new diagnoses were males and the Jackson MSA is comparable.
- Individuals 13-34 years of age comprise 66% of all new diagnoses in the State. In the Jackson MSA, 70% of new diagnoses are under age 35.
- Black non-Hispanics are disproportionately represented in the HIV/AIDS population. This group comprises 79% of new diagnoses and 74% of PLWH, but is 37% of the general population.
- MSM is the largest transmission category among newly diagnosed and PLWH. When combined with MSM who also inject drugs, they comprise 59% of new cases and 42% of PLWH. The Jackson MSA is similarly distributed.

HIGH RISK POPULATIONS

MSM and MSM/IDU are the predominant transmission modes in the State of Mississippi and the Jackson MSA. The issues facing these men shape their response to HIV status, access to medical care, and compliance to treatment regimens.

Younger men who represent the largest group of PLWH, have grown up in an era of explicit sex, social media and easy access to drugs. Moreover, many have come of age in the time of antiretroviral treatment (ART) and display little fear of HIV. They are more likely to use social media to engage in risky and anonymous sexual behaviors, but stigma and the risk of "being outed" remains a significant barrier to testing and linkage to care.

- Focus group respondents are concerned that young MSMs are engaging in anonymous sex with a high number of contacts.
- Another concern is that young teens using social media are often targeted by older PLWH.
- Along with the rise in young MSM testing positive has been an increase in other sexually transmitted diseases.
- Some MSMs have developed their own social networks where sex parties and drug use are the norm and revealing contacts is highly discouraged.

Black Non-Hispanic PLWH

Issues that result in barriers to Black non-Hispanic PLWH include:

- Distrust of institutions in general and the health care system in particular.
- Lack of questioning their partner's possible infidelity.
- Stigma and fear of disclosure to family and friends.

Out-of-Care PLWH

Out-of-care consumers have a variety of reasons for not accessing HIV care. Key reasons include:

- Lack of insurance or money to pay for co-pays.
- Homelessness or other more pressing needs.
- Mental health and substance abuse issues.
- Transportation barriers, especially in the more rural areas or areas where provider accessibility is problematic.

METHODOLOGY

Epidemiology Overview

The Epidemiological Overview provides detailed information on the current HIV epidemic, people at risk for HIV, and the overall demographics of the region. This information provides a picture of the region that supports services planning.

The Epidemiological Overview is based on 2014 data, the most recent year for which data are available and trended for five years of historical data. Data are provided for the State, its nine health districts, and the Jackson MSA.

The components of the Epidemiological Overview include a discussion of the geographical area(s) of study as related to the Mississippi communities affected by HIV infection. Sociodemographic and socioeconomic data are presented to provide a context for the analysis. Specific components are outlined below:

- Regional demographic data includes population, population growth, age, gender, race/ethnicity, and socioeconomic data including poverty level, income, education and insurance status. These data are provided for comparison to epidemiological data at the level available (e.g., statewide, planning district, MSA).
- Persons recently diagnosed with HIV/AIDS (incidence) includes race, age, sex, transmission category, current gender identity, and infection rates. Trend data provide a basis for insights into the direction the epidemic is taking and to identify population most likely to be at risk in the future.
- Persons living with HIV/AIDS (prevalence) includes age, gender, race/ethnicity, transmission mode, geographic location, deaths, etc. Absolute numbers and rates provide a basis for comparison. In addition, trend data allow for identification of changes in the epidemic.
- Indicators of risk for HIV infection in the population. Data used in this section are derived from behavioral surveillance data including National HIV Behavioral Surveillance System (NHBS), Youth Risk Behavioral Surveillance Risk Factor (YRBSS), Behavioral Risk Factor Surveillance System (BRYFSS), HIV surveillance data, STD, and tuberculosis data which are indicators of risky behavior and/or co-morbidities of the illness. HIV testing program data, RWHAP data, and ADAP data are also presented.
- Other Relevant Data. This section contains qualitative information gleaned from interviews, focus groups and surveys about barriers to testing and prevention, emerging risk groups and sexual behaviors, and the acceptance of Pre-Exposure HIV Prophylaxis (PrEP).

HIV Care Continuum

The HIV Care Continuum is a diagnosis-based model used by federal, state, and local agencies to gauge progress toward goals and to effectively direct HIV resources. This model has been used to depict graphically and in narrative format the Mississippi HIV Care Continuum in terms of the five stages: (1) HIV diagnosis, (2) linkage to care, (3) retention in care (4) antiretroviral use and, (5) viral suppression. Each stage is described as a percentage of the PLWH who are diagnosed.

The narrative describes the disparities in engagement of key/priority populations among the care continuum, and how the HIV Care Continuum is or could be used in planning, prioritizing, targeting, and monitoring resources needed by PLWH in Mississippi and improving the engagement of HIV diagnosed persons at each stage of the continuum.

Key Informant Interviews

Ten key informant interviews were conducted at the beginning of the Needs Assessment project. Interviews included

- Ryan White funded providers including community program directors, social workers, and physicians
- HOPWA providers
- Leadership of non-Ryan White funded organizations that address the needs of PLWH
- Professionals of the University of Mississippi Medical Center
- Public health officials

These interviews provided insight throughout the needs assessment. Specifically, interviews with:

- Ryan White funded providers laid the foundation for developing the focus group guides.
- AIDS Service Organizations/non-Ryan White funded service providers, identified additional needs and areas to explore.
- AIDS Services Organizations (ASOs) provided insight into the needs of the newly diagnosed, issues related to linkage to care after diagnosis, barriers to care and treatment, insight into out-of-care issues, and risk factors present in the region.
- Public Health officials and staff provided insight into current disease trends, and at risk populations.
- Educators provided insights into structural barriers and impact of ACA.

Focus Groups

Three provider focus groups were conducted in June 2016 in Jackson, Mississippi at the Jackson Medical Mall. The groups included Ryan White-funded medical providers, members of the Mississippi HIV Planning Council, and Ryan White case managers, outreach and Disease Interventional Specialists, and the Mississippi State Department of Health staff.

The Ryan White-funded medical providers consisted of eight participants representing physicians, nurses and administrators. The second group included 10 representatives of the Mississippi HIV Planning Council, and included consumers, providers and faith-based groups, and HIV prevention, education, and early intervention staff.

The third group consisted of case managers and other direct staff, and included 10 participants including administrators, case managers, housing care managers as well as outreach workers, and Disease Intervention Specialists.

Consumer Survey

A total of 319 consumer surveys were conducted throughout Mississippi at Ryan White provider locations. Google Forms™ was used for both administration and analysis. The following agencies participated in the administration of the survey and in the recruitment of survey respondents:

- Aaron E. Henry Community Health Center
- AIDS Services Coalition
- Coastal Family Health Center
- Delta Region Medical Center (Crossroad North)
- GA Carmichael Family Health Center
- Grace House
- Jackson Medical Mall Foundation
- MSDH Crossroads Clinic in Jackson
- My Brother's Keeper LGBTQ[2] Wellness Center (Gulfport)
- My Brother's Keeper Open Arms Healthcare Center
- Sacred Heart Southern Missions
- Southeast Mississippi Rural Health Initiative
- Southern Health Commission
- UMMC – Adult Special Care

Representatives from ADAP conducted the survey over the phone with clients, and flyers were distributed throughout the State notifying consumers of the survey and providing a web address so that it could be accessed via telephone, computer or tablet.

- The survey was available in English and Spanish.
- A $10 WalMart gift card was provided as an incentive for survey completion.

Out-of-Care Interviews

Twenty-two survey respondents met the expanded definition of out-of-care (see page 6). In addition, outreach workers and individuals working in the Medical Monitoring Program (MMP) were asked to assist in the recruitment of out-of-care consumers for an out-of-care interview. One respondent was recruited; in addition we sought and received permission to access a survey that was performed by the MMP in December 2015. Appropriate comments and suggestions are presented from these interviews as noted.

[2] Also referred to as Gender and Sexual Minorities by the Centers for Medicare and Medicaid.

Out-of-Care Consumer Definition

Consumers who have recently been out-of-care but are now in the care system provide excellent information about their reasons for not receiving care and their motivations for accessing treatment. The expanded out-of-care definition was used successfully in Dallas, Texas and PanWest-West Texas to assist case managers and outreach workers to solicit consumers for NSI consultant interview/surveys with very good results. Both providers and outreach workers were asked to identify and refer consumers that met the following expanded out-of-care definition.

1. Consumers not currently receiving HIV medical care, with at least 12 months since the last medical appointment. These people may or may not be receiving other Ryan White or HIV services.
2. Consumers diagnosed between 2012 and 2015 that failed to link to care within six months of diagnosis. These consumers may currently be in care.
3. Consumers diagnosed between 2012 and 2015, linked to care after diagnosis but dropped out-of-care for at least six months. These consumers may now be back in care.
4. Consumers who dropped out-of-care for 12 months but are now back in care. Preference will be given to consumers who have been back in care for no more than 18 months.

This definition has provided information about consumers' reasons for being out-of-care, why they entered/re-entered care, and what is required to maintain them in care.

Overview of Survey Respondents

Consumers completed surveys at provider sites in Mississippi, others were conducted with ADAP clients over the telephone, and others were completed on consumers own electronic devices. Table ES.1 presents the number of and percentage of survey participants residing in each Public Health District.

Table ES.1
Number and Percentage of Survey Participants from Health Districts

	Completed Surveys		Ryan White Clients	
	Number	**Percent**	**Number**	**Percent**
District 1	25	7.8%	765	8.1%
District 2	4	1.3%	516	5.5%
District 3	39	12.2%	921	9.7%
District 4	5	1.6%	456	4.8%
District 5	152	47.6%	3,813	40.3%
District 6	16	5.0%	601	6.4%
District 7	8	2.5%	450	4.8%
District 8	30	9.4%	789	8.3%
District 9	40	12.5%	1,139	12.1%

It should be noted that the consumer survey included both in care and out-of-care consumers who meet the expanded definition of out-of-care as described on page 6.

Statewide and Jackson MSA

A comparison between the Mississippi epidemiology and consumer survey respondents is presented below.

- Approximately 52% of survey respondents are men, compared to 63% of the epidemic, and over 2% of those completing the survey were transgender (male to female) in Mississippi.
- In the Jackson MSA 55% of survey respondents were men, compared to 69% of PLWH, and nearly 4% were transgender (male to female) in the Jackson MSA.

Gender

Table ES.2
Mississippi State PLWH by Gender

Gender	*2014 Epidemiology n=9,456*	*Consumer Survey n=319*
Male	62.9%	52.2%
Female	30.8%	42.6%
Transgender	N/R	2.2%

Table ES-3
Jackson MSA PLWH by Gender

Gender	*2014 Epidemiology n=3,603*	*Consumer Survey n=130*
Male	69.1%	55.4%
Female	30.9%	40.8%
Transgender (male to female)	N/R	3.8%

Age Cohort

- Nearly 9% of Mississippi consumer respondents were under the age of 25, compared to 6% PLWH. Fifty-one percent of survey respondents compared to 44% of PLWH were aged 25-44.
  - Those over 45 were 50% of Mississippi PLWH, compared to 39% of consumer respondents.
- In the Jackson MSA no survey respondents were under the age of 14 and 39% were 15-34, compared to 0.1% of PLWH who were under 14 and 22% who were 15-34.
  - Those 45-64 were nearly 50% of the epidemic and 34% of survey respondents.

Table ES.4
Mississippi State PLWH by Age Cohort

Age Cohort	*2014 Epidemiology n=9,456*	*Consumer Survey n=319*
<25	6.3%	8.8%
25-44	43.5%	50.5%
45-54	30.0%	25.4%
55+	20.2%	13.8%
No Response	0.0%	1.6%

Table ES.5
Jackson MSA PLWH by Age Cohort

Age Cohort	*2014 Epidemiology n=3,604*	*Consumer Survey n=130*
<14	0.1%	0.0%
15-34	22.2%	39.2%
35-44	24.0%	24.6%
45-64	48.9%	33.8%
65+	4.7%	0.8%
No Response	0.0%	1.5%

Race/Ethnicity

- Seventy-four percent of Mississippians living with HIV are Black, compared to 88% of consumer respondents.
  - Whites were 9% of the survey respondents, and 20% of PLWH in Mississippi.
  - Hispanics were 1% of the consumer survey respondents, and 2% of PLWH.
- Blacks are 81% of the PLWH in the Jackson MSA, and 92% of the survey respondents from the Jackson MSA.
  - Whites were 14% of PLWH in the Jackson MSA, and were 6.2% of respondents.
  - There were no Hispanic respondents in the consumer survey.
  - People of multiple races/other races were 2.7% of PLWH, and 2.3% of survey respondents.

Table ES.6
Mississippi State PLWH by Race/Ethnicity

Race/Ethnicity	*2014 Epidemiology n=9,456*	*Consumer Survey n=319*
Black	74.2%	87.8%
White	20.1%	9.1%
More than one race	2.8%	0.9%
Asian/Pacific Islander/Other	0.3%	0.9%
Hispanic	2.3%	1.3%

Table ES.7
Jackson MSA PLWH by Race/Ethnicity

Race/Ethnicity	*2014 Epidemiology n=3,577*	*Consumer Survey n=130*
Black	81.2%	91.5%
White	14.3%	6.2%
More than one race	2.7%	2.3%
Asian/Pacific Islander/Other	N/R	0.0%
Hispanic	1.8%	0.0%

Transmission Mode

- The percent of Mississippi PLWH with MSM transmission mode (39%) as reported in the epidemiology data is likely under-reported and Other/Unknown transmission mode (35%) does not compare closely to the percentages obtained in the survey. This factor creates broad discrepancies in the comparison of MSM survey respondents to PLWH.
  - Heterosexual transmission mode is 17% of Mississippi PLWH, and 18% of survey respondents.
  - IDU transmission rates are 5% for PWLH, and 3% of survey respondents.
- A similar situation occurs in the Jackson MSA, 39% of PLWH have an unknown transmission mode, compared to 8% of survey respondents.
  - Heterosexual transmission among Jackson MSA PLWH accounted for 15% of infections, compared to 15% of survey respondents.
  - IDU transmission mode accounts for 5% of infections among Jackson MSA PLWH, compared to 1% of survey respondents.

Table ES.8
Mississippi State PLWH by Transmission Mode

Transmission Mode	*2014 Epidemiology n=9,456*	*Consumer Survey n=319*
MSM	39.4%	66.5%
IDU	4.5%	2.5%
Heterosexual	17.2%	17.6%
Bisexual contact	N/R	3.1%
Perinatal	0.7%	N/R
MSM/IUD	2.8%	N/R
Other/Unknown	35.3%	10.3%

Table ES.9
Jackson MSA PLWH by Transmission Mode

Transmission Mode	*2014 Epidemiology n=3,604*	*Consumer Survey n=130*
MSM	36.9%	75.4%
IDU	5.0%	0.8%
Heterosexual	15.4%	14.6%
Bisexual contact	N/R	1.5%
Other/Unknown	39.0%	7.7%

KEY FINDINGS AND RECOMMENDATIONS

Finding #1

Efforts to implement the National HIV/AIDS Strategy (NHAS) for the U.S. to:

1. Reduce new HIV/AIDS infections
2. Increase access to care and improve health outcomes for PLWH
3. Reduce HIV-related disparities and health inequities
4. Achieve a more coordinated response to the HIV epidemic

are severely hampered by insufficient Federal and State funding.

Recommendations

- Develop a coalition of southern states and HIV advocates to advocate for a fair Federal funding formula to account for the burden of HIV disease in the south.
- Encourage state law makers to expand Medicaid funding as allowed under the ACA.
- Seek to expand State funding of prevention programs directed at the general community to enhance awareness, dispel myths, and support the public health agenda.

Finding #2

Stigma is a complex and multifaceted phenomenon, which combined with fear of disclosure acts as a significant barrier to encouraging those at high risk from being tested and receiving care in Mississippi.

Recommendations

- Public policy dictates the Department of Health's responsibilities for surveillance, and must ensure notification of possible exposure will be confidential and that the parties involved will not be prosecuted.
- Support evidence-based prevention messages that reduce stigma and educate the general public about HIV and its transmission.
- Ensure that all employees of HIV care sites funded with Part B monies receive ongoing training in client-centered care, cultural sensitivity, and HIPAA requirements.
- Ensure that all Ryan White-funded sites have grievance provisions to investigate claims of HIPAA violations and that procedures exist to ensure disciplinary actions are taken against employees found to violate client confidentiality.
- Support early intervention services that utilize community outreach workers, peer navigators or patient navigators to shorten the timeframe for linkage to care to less than the HAB standard, ideally to within one week of diagnosis. Peer navigators/community health workers may also serve to help build trusted relationships, support HIV testing, and physically bring new and repeat positives to their clinical appointments for at least six weeks following linkage to care.

Finding #3

Low health literacy levels compound the problem of HIV stigma in Mississippi and require a comprehensive strategy for HIV prevention, education and testing.

Recommendations

- The statewide educational strategy should promote routine testing for all persons and provide counseling about testing and results.
- Develop innovative strategies to educate mothers, wives, girlfriends and partners of those at risk about creating conversations with loved ones and friends about prevention.
- Utilize multimedia campaigns (e.g. print, billboards, infographics, social media, TV and radio) to educate the general population as well as those at highest risk for HIV.
- Fund community-based organizations to bring the conversation to faith-based organizations, barber shops, beauty salons, AA and NA groups, and other groups within the community.
- Initiate a program to improve health literacy for all receiving care and support services under RWHAP.

Finding #4

As the major coordinating body for HIV funds, the Mississippi State Department of Health has an excellent opportunity to encourage collaboration, sharing of evidence-based best practices, and enhancing efforts to reduce mortality rates and increase viral load suppression.

Recommendations

- Coordinate all RWHAP-funded clinics in an expanded, more structured quality management program and utilize the clinical database for frequent reporting of quality indicators.
- Develop physician collaboratives with nursing and case management.
- Enhance data systems via the integration of surveillance, ADAP, care and HOPWA data.

Finding #5

Given resource constraints, Mississippi does an excellent job with stretching limited resources. Coordination among various other divisions within the Department of Health and other entities of State Government could enhance efforts to serve the needs of PLWH and those at risk for infection.

Recommendations

- Work with Primary Health Care Association, Mississippi Department of Mental Health to encourage better coordination of primary medical care and community-based mental health and substance abuse services to PLWH and to provide routine testing for HIV on an opt-out basis (e.g., seek to integrate these providers into the HIV provider network even though many may not be currently funded).
- Develop a comprehensive plan with the Department of Corrections for care and treatment of incarcerated PLWH to ensure those scheduled for release are promptly linked to care in the community.
- Encourage cooperation between State and local health departments and school districts to ensure high school students are provided with evidence-based, age-appropriate information about HIV and other sexually transmitted diseases as part of a health education program

grounded in the benefits of abstinence, while ensuring that young people who are sexually active (nearly 50% of Mississippi high school students) have the information they need to protect themselves from sexually transmitted infections (STIs) or other unintended consequences.
- Work with the State Board of Medical Licensure and the Medical Society to ensure that all physicians abide by rules for reporting all persons who test positive for HIV, and are encouraged to ask their patients about their sexual activity and use of PrEP.

Finding #6

While 38% of Mississippi's PLWH live in the Jackson MSA, more than half are living in rural areas of the State that are not well served by medical and dental providers, and which lack transportation networks.

Recommendations
- To ensure that services are as equitably distributed as possible given the State's rural character, enhance funding to provide transportation services.
- Fund HIV medical providers or FQHCs in areas lacking services (Health Districts 4 and 6), and consider the use of telemedicine services to link private physicians to infectious disease specialists in Jackson, including the University of Mississippi Medical Center.
- Enhance funding for dental services in rural areas of the State, and work with the Primary Care Association to ensure that FQHCs with dental services are serving PLWH.

Finding #7

The high poverty rate in Mississippi adds to difficulties that PLWH encounter in getting into and staying in care.

Recommendations
- Enhance funding for HOPWA services and for assistance with co-pays, deductibles, and insurance premium costs to assist PLWH achieve viral load suppression.
- Fully fund ADAP to meet comprehensive pharmaceutical needs of PLWH.

Finding #8

Funding shortages for HIV-specific services have been and are likely to continue. To ensure that PLWH receive their fair share of benefits, enhance communication and collaboration between RWHAP and community-based providers.

Recommendations
- Enhance referral relationships through the development of formal referral agreements or Memoranda of Understanding and, with the client's consent, sharing of patient health information (PHI).
- Seek counsel from non-funded community-based organizations, ASOs and PLWH on polices that impact prevention and care services delivery.
- Establish coalitions to coordinate efforts that maximize HIV testing, linkage and retention in care.

A. EPIDEMIOLOGIC OVERVIEW

GEOGRAPHIC REGION

The State of Mississippi, located at the southern tier of the United States, borders Alabama to the east, Louisiana and Arkansas to the west and the Gulf of Mexico at the southern border. The 2014 population was estimated at 2,984,345, slightly less than 1% of the U.S. population.[3] Since the 2010 U.S. Census, population growth has averaged 1.4%, less than .4% annually. The State is 49% male, 20% between age 20-34 (the age most at risk for HIV), 58% White, non-Hispanic, 37% Black, non-Hispanic, and relatively young with a median age of 36.3 years compared to 37.4 nationwide.

In the state, economic conditions are poor. Eighteen percent are without high school diploma, and 23% are living below the Federal Poverty Level (FPL). This compares poorly to national averages where 14% did not complete high school and 16% were below FPL. The Statewide median household income of $39,464 ranks last in the nation. The national average median income is $53,482. Further, Mississippi ranks next-to-last among persons with a Bachelor's degree or higher.

Mississippi is divided into nine public health districts (PHD) with populations ranging from 173,000 in District 7 to 638,862 in District 5. Demographic characteristics across the public health districts vary in terms of population growth, age, race/ethnicity, educational attainment and income. To summarize:

- District 9 has seen a 4% population growth since 2010, the highest of the nine districts. District 3 lost 4% of its population during the same time.
- The oldest population resides in District 7 with 30% over age 55. District 3, with 29% under age 20, has the largest cohort of children, and District 4 with 10%, has the largest cohort of young adults age 20-24.
- Black, non-Hispanics are most concentrated in District 3 with 67% of the population representing that race.
- In terms of educational attainment, 28% of District 5 residents completed some form of higher learning while 26% of District 3 did not complete high school.
- The median household income ranges from $28,124 (District 3) to $44,018 (District 9). Similarly, 35% of residents in District 3 are below the Federal Poverty Level, compared to the statewide average of 23%.

County Health Rankings 2016 reports worse health outcomes and health factors as a State than the U.S. median for all five health outcomes indicators and most health factors indicators.[4]

[3] U.S. Census Bureau American Community Survey 2014 Five Year Estimates. All population statistics are from this source. See also Jacob S. Hacher and Paul Pierson, Analysis based on data from the Census Bureau, Bureau of Economic Analysis, etc., The New York Times, July 31, 2016.

[4] University of Wisconsin, Population Health Institute and the Robert Wood Johnson Foundation, 2016 County Health Rankings Mississippi.

Figure A.1
State of Mississippi Health Districts

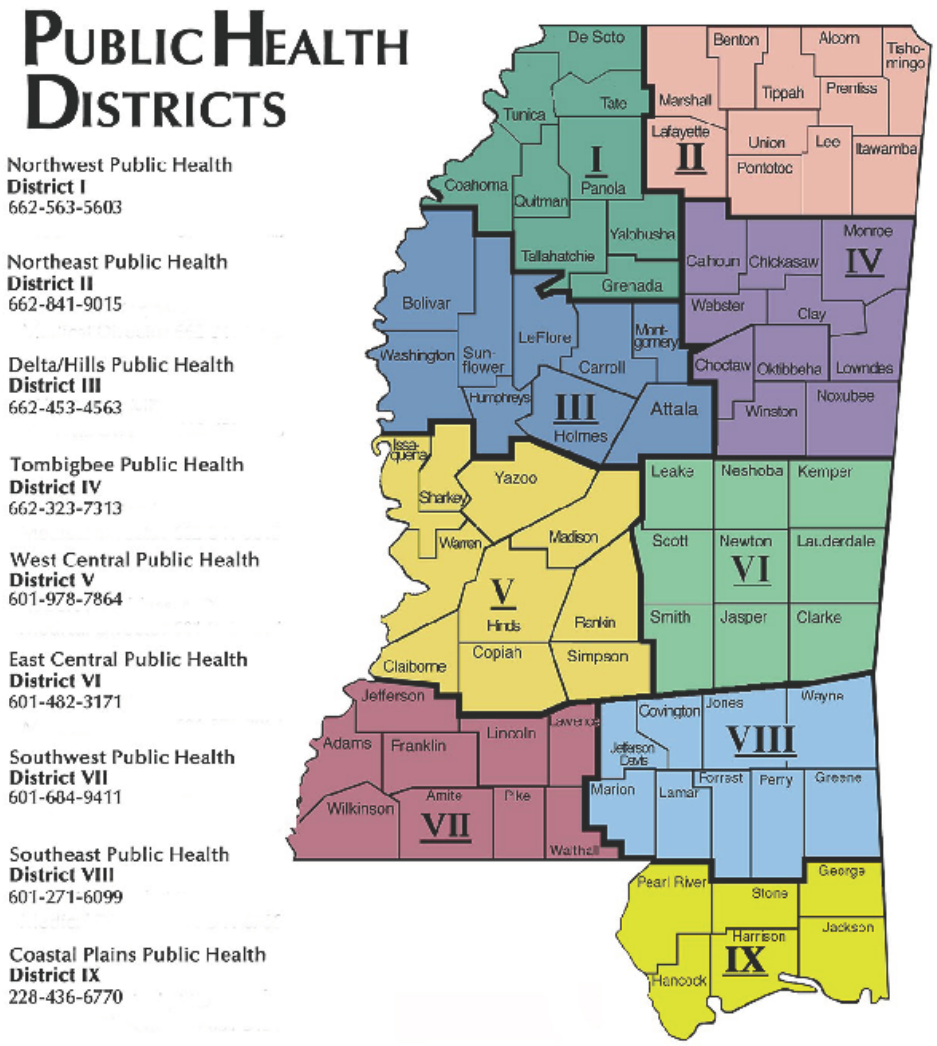


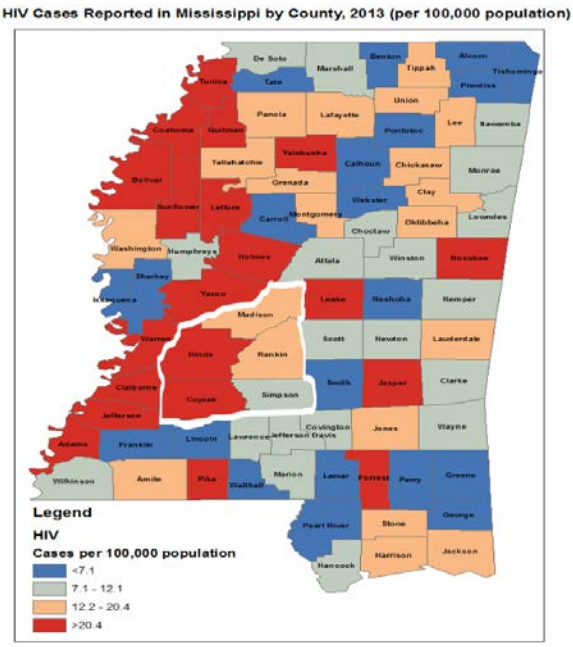
Table A.1
State of Mississippi Health Districts and Counties

Districts and Counties	2014 Population	Counties of Interest
District 1 Northwest —9 Counties Coahoma, Desoto, Grenada, Panola, Quitman, Tate, Tallahatchie, Tunica, Yalobusha	**322,559**	Coahoma Desoto Tallahatchie Yalobusha
District 2 Northeast —11 Counties Alcorn, Benton, Itawamba, Lafayette, Lee, Marshall, Pontotoc, Prentiss, Tippah, Tishomingo, Union	**365,596**	Benton Lee Pontotoc
District 3 Delta/Hills —9 Counties Attala, Bolivar, Carroll, Holmes, Humphreys, Leflore, Montgomery, Sunflower, Washington	**212,511**	Bolivar Humphreys Leflore Washington
District 4 Tombigbee —10 Counties Calhoun, Chickasaw, Choctaw, Clay, Lowndes, Monroe, Noxubee, Oktibbeha, Webster, Winston	**245,987**	Chickasaw Lowndes Noxubee Oktibbeha
District 5 West Central —10 Counties Claiborne, Copiah, Hinds, Madison, Rankin, Simpson, Sharkey, Issaquena, Warren, Yazoo	**638,862**	**Copiah** **Hinds** **Madison** **Rankin** **Simpson** Yazoo
District 6 East Central —9 Counties Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Scott, Smith	**243,058**	
District 7 Southwest —9 Counties Adams, Amite, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall, Wilkinson	**173,000**	Pike Wilkinson
District 8 Southeast —9 Counties Covington, Forrest, Greene, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne	**307,606**	Forrest Jefferson Davis Marion Wayne
District 9 Coastal Plains —6 Counties George, Hancock, Harrison, Jackson, Pearl River, Stone	**475,166**	Hancock Harrison Stone
Counties of Interest = Reported Diagnoses >20 or Incidence Rate >16.2 *Mississippi epicenters in* **bold***.* *Population Data Source: U.S. Census Bureau State and County American Community Survey (ACS), 2014 Five-Year Estimates*		

To identify areas with highest concentrations of HIV/AIDS, each county was compared to statewide incidence cases and rates. Those with 20 or more new cases or incidence rate greater than 16.2 were considered counties of interest. Further, the Jackson Metropolitan Statistical Area (MSA)[5] which includes five counties – Copiah, Hinds, Madison, Rankin and Simpson – was identified by the Centers for Disease Control as the epi-center of HIV in Mississippi. Demographic characteristics of Jackson MSA are summarized as follows.

- Jackson MSA represents the area of greatest population growth in the state. From 2010 to 2014, the population grew from 533,673 to 574,998 (8%).
- By gender, approximately 52% of Jackson MSA is female with similar distributions statewide.
- The median age of Jackson MSA residents is 35.3 compared to 36.3 statewide and 37.4 in the U.S. The population cohort age 25-34 at 14% exceeds the statewide average of 12.5%.
- Jackson MSA has a greater concentration of Black, non-Hispanics than found statewide, 47% compared to 37%.
- Compared to statewide averages, Jackson MSA is relatively well educated. Twenty-nine percent completed programs in higher education compared to 20% statewide. In Mississippi, 18% did not complete high school; however, Jackson MSA's record was 14% and just slightly above the national average (13.6%).
- Income levels in Jackson MSA exceed statewide averages as well. Median household income in 2014 reached $45,366 in Jackson MSA compared to $39,464 statewide. However, it is important to note that all of Mississippi and Jackson MSA fell significantly below the U.S. average median household income of $53,482.
- Similarly, the percentage of persons below FPL in Jackson MSA was reported at 20% compared to 23% statewide. As with income levels, the FPL indicator for Jackson MSA and the state were above the national average of 16%.

Figure A.2
Jackson MSA



[5] Referred to as Jackson MSA in this report.

Table A.2
State of Mississippi
Demographic Characteristics by Health District and Jackson MSA

Population Change 2010-2014			
	2010 Population	**2014 Population**	**% Change**
District 1	314,052	322,559	2.71%
District 2	356,380	365,596	2.59%
District 3	221,629	212,511	-4.11%
District 4	246,754	245,987	-0.31%
District 5	627,583	638,862	1.80%
District 6	243,609	243,058	-0.23%
District 7	175,599	173,000	-1.48%
District 8	300,197	307,606	2.47%
District 9	456,188	475,166	4.16%
Jackson MSA	533,673	574,998	7.74%
Mississippi	2,941,991	2,984,345	1.44%

Gender		
	Male	**Female**
District 1	48.6%	51.4%
District 2	48.7%	51.3%
District 3	48.0%	52.0%
District 4	48.2%	51.8%
District 5	47.9%	52.1%
District 6	48.4%	51.6%
District 7	48.8%	51.2%
District 8	48.7%	51.3%
District 9	49.5%	50.5%
Jackson MSA	48.0%	52.0%
Mississippi	48.5%	51.5%

(Tables continues)

Age						
	Under 20	**20-24**	**25-34**	**35-44**	**45-54**	**55+**
District 1	29.4%	6.5%	12.7%	13.8%	13.7%	23.9%
District 2	27.4%	8.0%	12.4%	12.6%	13.3%	26.4%
District 3	29.2%	7.4%	12.7%	11.5%	13.1%	26.1%
District 4	26.6%	10.3%	12.2%	11.5%	12.9%	26.5%
District 5	28.3%	7.1%	13.9%	12.9%	13.6%	24.2%
District 6	28.5%	6.6%	12.2%	12.2%	13.2%	27.4%
District 7	26.8%	6.3%	11.8%	11.9%	13.8%	29.5%
District 8	27.5%	8.3%	13.8%	12.2%	13.0%	25.2%
District 9	27.1%	6.9%	13.1%	12.6%	14.2%	26.0%
Jackson MSA	28.3%	7.1%	14.1%	13.0%	13.1%	23.9%
Mississippi	27.9%	7.5%	12.8%	12.4%	13.4%	26.1%

Race/Ethnicity							
	Hispanic	**American Indian/ Alaska Native**	**Asian, non-Hispanic**	**Black, non-Hispanic**	**Native Hawaiian/ Pacific Islander**	**White, non-Hispanic**	**Multiple Races, non-Hispanic**
District 1	3.7%	0.1%	0.9%	35.9%	0.0%	58.3%	1.1%
District 2	3.0%	0.2%	0.7%	20.8%	0.0%	74.3%	1.0%
District 3	1.4%	0.4%	0.4%	65.2%	0.1%	32.0%	0.5%
District 4	1.7%	0.3%	1.0%	40.2%	0.1%	56.1%	0.6%
District 5	2.2%	0.4%	1.2%	48.3%	0.0%	47.2%	0.7%
District 6	2.8%	3.5%	0.5%	36.9%	0.1%	55.5%	0.7%
District 7	1.6%	0.4%	0.3%	47.0%	0.0%	50.2%	0.5%
District 8	2.5%	0.6%	0.7%	30.8%	0.0%	64.4%	0.9%
District 9	4.2%	1.0%	2.3%	18.8%	0.1%	71.8%	1.8%
Jackson MSA	2.1%	0.2%	1.0%	47.3%	0.0%	48.6%	0.8%
Mississippi	2.8%	0.4%	0.9%	36.7%	0.0%	58.3%	0.9%

(Table continues)

Educational Attainment				
	No High School Diploma	**High School Graduate/ GED**	**Some College, Associate's Degree**	**Bachelor's, Professional, or Graduate Degree**
District 1	17.1%	30.9%	33.6%	18.4%
District 2	20.5%	31.9%	30.0%	17.6%
District 3	26.4%	29.8%	27.1%	16.8%
District 4	20.6%	30.6%	28.1%	20.7%
District 5	14.2%	25.8%	31.6%	28.4%
District 6	20.2%	32.8%	32.1%	14.9%
District 7	20.7%	34.9%	29.1%	15.3%
District 8	19.0%	30.6%	29.8%	20.6%
District 9	14.5%	31.3%	35.0%	19.3%
Jackson MSA	13.9%	25.3%	31.8%	28.9%
Mississippi	18.1%	30.2%	31.3%	20.4%

Median Household Income and Population Below Federal Poverty Level		
	Median Household Income	**Below Federal Poverty Level**
District 1	$ 37,064.50	25.6%
District 2	$ 36,645.09	21.0%
District 3	$ 28,124.11	34.5%
District 4	$ 32,650.30	27.1%
District 5	$ 38,390.20	26.0%
District 6	$ 34,563.22	24.4%
District 7	$ 32,152.56	27.5%
District 8	$ 34,922.67	24.7%
District 9	$ 44,018.17	19.0%
Jackson MSA	$ 45,366.00	19.9%
Mississippi	$ 39,464.00	22.6%
Source: U.S. Census Bureau ACS 2014, **Numbers given represent averages of all counties within respective districts*		

Uninsured

Access to health insurance is considered critical to optimal health status. In Mississippi, the percentage of uninsured exceeds national averages significantly. Most recent U.S. Census estimates of 24% uninsured between age 18 and 65 in Mississippi compares to 20% nationwide. This translates to approximately 500,000 individuals exclusive of children, youth and seniors uninsured in the State. By district, highest rates of uninsured are District 3, District 8 and District 9. Jackson MSA, with 21% uninsured, declined 2% from 2012 to 2014.

Throughout the nation, uninsured rates have declined since 2014 as a result of implementation of the Affordable Care Act. Although Census estimates are not available for 2015, Enroll America has published 2013 and 2015 estimates with the following observations.[6]

- Current uninsured rates in Mississippi have declined since 2013 prior to the first open enrollment period.
- The largest cohorts of currently uninsured are Hispanics, Blacks and young adults age 18-24.
- More uninsured people live in Hinds County (PHD 5) and Harrison County (PHD 9). The highest uninsured rates are found in Neshoba County (PHD 6), Washington County (PHD 3), Leflore County (PHD 3) and Leake County (PHD 6). Hinds County in the Jackson MSA is an HIV epi-center.

It is important to note that Mississippi has declined to offer Medicaid Expansion as part of the Affordable Care Act. Therefore, reductions in uninsured rates are likely to be slower than the national experience, and low income individuals will likely remain uninsured due to the costs of coverage.

Table A.3
Uninsured Estimates
2012 and 2014

Uninsured Rates, Age 18-64 Health Districts*, Jackson MSA, MS			
	2012	**2014**	**% change**
District 1	27.3%	25.5%	-1.9%
District 2	23.9%	24.0%	0.1%
District 3	27.3%	28.1%	0.7%
District 4	25.3%	25.2%	-0.1%
District 5	26.4%	25.4%	-1.1%
District 6	24.4%	24.3%	-0.1%
District 7	26.6%	25.8%	-0.8%
District 8	26.0%	27.0%	1.0%
District 9	28.3%	27.5%	-0.8%
Jackson, MS MSA	22.2%	20.6%	-1.7%
Mississippi	24.6%	24.3%	-0.3%

*Source: US Census Bureau ACS 5-year estimate, *represents average of counties within each respective health district.*

[6] Enroll America, https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2015/11/ MS_snapshot.pdf

Table A.4
Uninsured Estimates 2013 and 2015

	2013	2015
U.S. Average	16.4%	10.7%
Mississippi	22.2%	17.3%
Note: Estimates are from Enroll America and differ slightly from U.S. Census data.		

Socio-Demographic Characteristic of Persons Newly Diagnosed, PLWH and Persons at Higher Risk for HIV Infection

As of December 31, 2014, 15,580 cases of HIV/AIDS have been reported in the State of Mississippi. Of these, 9,456 or 316.9 per 100,000 population are living with the disease (PLWH). In 2014, 484 persons were newly diagnosed or 16.2 per 100,000. Jackson MSA, consisting of Hinds, Madison, Copiah, Rankin and Simpson counties, accounts for 38% of all PLWH and 35% of all PLWH in the State.[7] According to the Center for Disease Control and Prevention, Mississippi had the 9th highest rate of new HIV diagnoses in the nation in 2013, and Jackson MSA was ranked 4th among metropolitan statistical areas.[8]

Table A.5
Prevalence and Incidence of HIV/AIDS 2014

Mississippi		**Jackson MSA**	
New Dx			
Cases	484	**Cases**	171
Rate	16.2	**Rate**	31.3
PLWH			
Cases	9,456	**Cases**	3,604
Rate	316.9	**Rate**	659.0
Rates are per 100,000 population. *Source: MSDH HIV/STD Office*			

Cumulative Reported Cases

From 2009 to 2014, cumulative reported cases of HIV/AIDS in Mississippi increased by 2,405 (18%) from 13,175 to 15,580. New cases per year between 2010 and 2014 ranged from 462 to 484, with the greatest number reported in 2011 at 533. The rate of increase was greatest among males, Blacks, persons age 25-44, and MSM. Persons age 15-24 and transmission by injecting drugs also noteworthy experienced noteworthy increases.

[7] All reference to State of Mississippi epidemiologic data are from Mississippi Department of Health HIV/STD Office. Rates are calculated from U.S. Bureau of the Census annual estimates of the population.
[8] Centers for Disease Control and Prevention, "HIV Surveillance Report, 2014" vol. 26. http://www.cdc.gov/hiv/library/reports/surveillance. Published November 2015.

Table A.6
Cumulative Reported Cases of HIV/AIDS by Selected Demographic Variable
2009 -2014

	Cumulative Cases Through 2009	2010	2011	2012	2013	2014	Cumulative Cases Through 2014
Male	9,340	348	394	359	361	374	11,176
Black, Not Hispanic	**9,447**	**360**	**409**	**342**	**370**	**380**	**11,308**
Age 15 to 24	**2,730**	**127**	**159**	**143**	**158**	**152**	**3,469**
Age 25 to 44	7,998	224	239	196	219	232	9,108
Male-to-male sex	**4,633**	**203**	**253**	**255**	**249**	**282**	**5,875**
Total	13,175	462	533	447	479	484	15,580

Mortality

Reported deaths from HIV/AIDS reached 6,124 in 2004, 39.3% of cumulative reported cases. Deaths have averaged approximately 202 persons per year with relative consistency. The largest number of deaths occurred in 2013.

In 2013, the overall mortality rate in Mississippi reached 7.5 per 100,000 population, one of the highest in the nation. Average mortality in 2013 was reported at 5.1 in the nation and 6.4 in the southern U.S. region.[9] In 2014, mortality in Mississippi declined to 5.4/100,000.

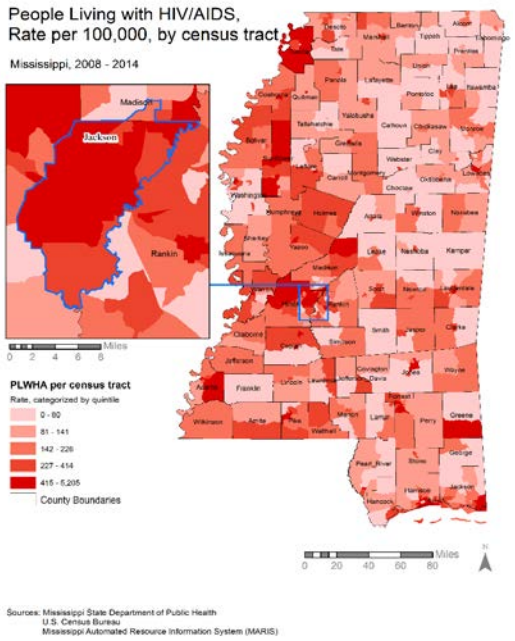
Table A.7
Deaths Among Persons with Diagnosis of HIV
2010-2014 and Cumulative

	Cumulative Deaths Through 2009	2010	2011	2012	2013	2014	Cumulative Deaths Through 2014
	No.	**No.**	**No.**	**No.**	**No.**	**No.**	**No.**
Total	**5,112**	**205**	**221**	**192**	**223**	**171**	**6,124**

[9] Centers for Disease Control and Prevention, "HIV Surveillance Report, 2014" vol. 26. http://www.cdc.gov/hiv/library/reports/surveillance. Published November 2015.

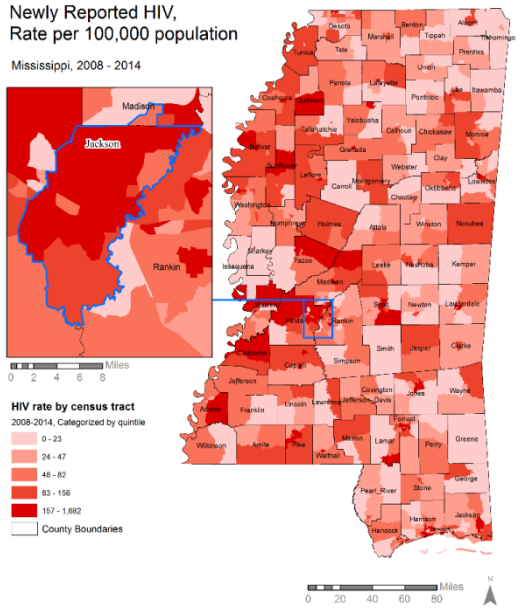
The profile of HIV/AIDS in Mississippi weighs heavily on males, young adults, Blacks and men who have sex with men (MSM). The following describes each demographic category for the State of Mississippi and Jackson MSA.

Figure A.3



Sources: Mississippi State Department of Public Health
U.S. Census Bureau
Mississippi Automated Resource Information System (MARIS)

Figure A.4



Sources: Mississippi State Department of Public Health
U.S. Census Bureau
Mississippi Automated Resource Information System (MARIS)

Gender

Males represent more than three-quarters of all new diagnoses and two-thirds of persons living with HIV/AIDS. In 2014, 77% of all new diagnoses were male. The Jackson MSA is comparable. Data to quantify the transgender population are not available.

Table A.8
HIV/AIDS by Gender
State of Mississippi and Jackson MSA 2014

	New Dx		PLWH	
	Cases	**%**	**Cases**	**%**
Mississippi				
Female	110	22.7%	2,913	30.8%
Male	374	77.3%	6,543	69.2%
Total	484	100.0%	9,456	100.0%
Jackson MSA				
Female	38	22.4%	1,114	30.9%
Male	132	77.6%	2,489	69.1%
Total	170	100.0%	3,603	100.0%

Age

Individuals age 13-34 comprise 66% of all new HIV/AIDs diagnoses in Mississippi, representing a significant population at risk for infection. PLWH are more often distributed among older cohorts with 50% over age 45. In Jackson MSA, 70% of new diagnoses are under age 35 while 54% of PLWH are over age 45.

Table A.9
HIV/AIDS by Age Cohort
State of Mississippi and Jackson MSA 2014

A. Mississippi

	New Dx		PLWH	
	Cases	**%**	**Cases**	**%**
Under 13	0	0.0%	13	0.1%
13-24	153	31.6%	587	6.2%
25-34	165	34.1%	1,862	19.7%
35-44	67	13.8%	2,248	23.8%
45-54	59	12.2%	2,838	30.0%
55+	40	8.3%	1,908	20.2%
Total	484	100.0%	9,456	100.0%

(Table continues)

B. Jackson MSA

New Dx		
	#	%
13-24	59	34.5%
25-34	60	35.1%
35-44	23	13.5%
45-54	16	9.4%
55-64	13	7.6%

PLWH		
	#	%
<14	5	0.1%
15-34	800	22.2%
35-44	864	24.0%
45-64	1,764	48.9%
65+	171	4.7%

Race/Ethnicity

Black, non-Hispanics represent the largest number of new diagnoses and PLWH in Mississippi. More than three-quarters of the HIV/AIDS population is Black, non-Hispanic. Whites are second highest both in terms of incidence and prevalence. The Jackson MSA is more heavily Black with 88% of new diagnoses and 81% of PLWH from that race. In Mississippi, Hispanics represent less than 3% of new diagnoses and PLWH. Likewise, Hispanics are minimally represented in Jackson MSA.

Black, non-Hispanics are disproportionately represented in the HIV/AIDS population. Black, non-Hispanics comprise 79% of new HIV/AIDS diagnoses and 74% of PLWH but 37% of the general population.

Table A.10
HIV/AIDS by Race/Ethnicity
State of Mississippi and Jackson MSA 2014

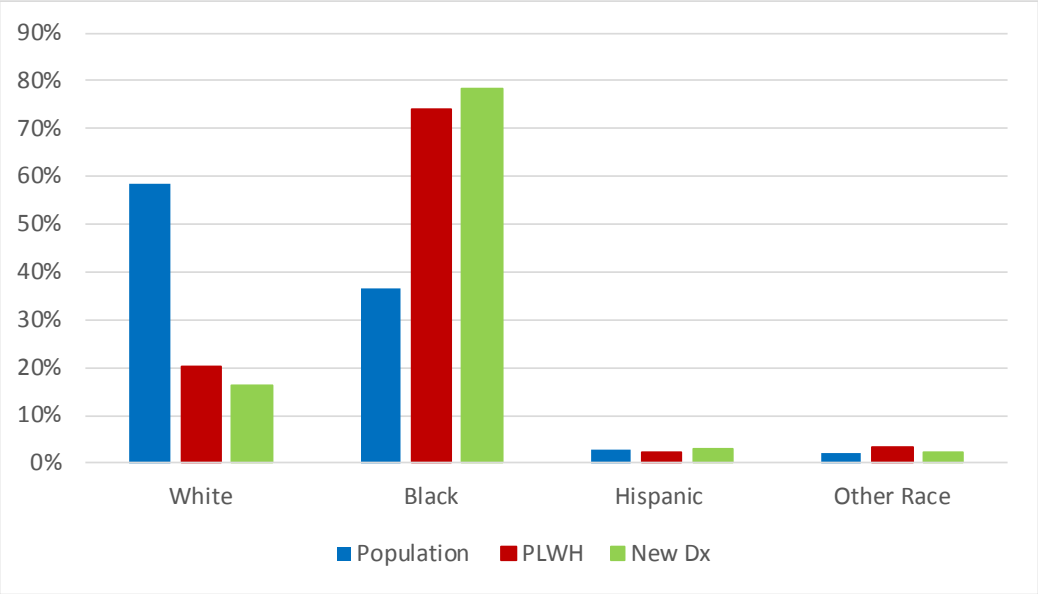
	New Dx		PLWH	
	#	%	#	%
Mississippi				
Hispanic	14	2.9%	219	2.3%
American Indian/Alaska Native, non-Hispanic	0	0.0%	8	0.1%
Asian, non-Hispanic	*	0.2%	15	0.2%
Black, non-Hispanic	380	78.5%	7,016	74.2%
Native Hawaiian/Pacific Islander, non-Hispanic	0	0.0%	*	0.0%
White, non-Hispanic	79	16.3%	1,900	20.1%
Multiple Races, non-Hispanic	10	2.1%	264	2.8%
Total	484	100.0%	9,456	100.0%
Jackson MSA				
Hispanic	*	1.2%	64	1.8%
Black, non-Hispanic	151	88.3%	2,905	81.2%
White, non-Hispanic	15	8.8%	512	14.3%
Multi-race, non-Hispanic	*	1.8%	96	2.7%
Total	171	100.0%	3,577	100.0%

Note: Quantities less than five are not reported.

Disproportionate Impact

When comparing the racial/ethnic distribution in Mississippi to the corresponding distribution among HIV/AIDS populations, there is a disproportionate impact of HIV/AIDS among Blacks in Mississippi. Blacks comprise 37% of the State's population but 74% of new HIV/AIDS diagnoses and 79% of PLWH. Proportionately, there are more Whites and Hispanics in the general population than the HIV/AIDS population.

Figure A.5
Disproportionate Impact 2014



Transmission Categories

Male-to-male sex (MSM) is the largest transmission category among both newly diagnosed and PLWH. When combined with MSM who also injected drugs (MSM/IDU), 59% of new cases and 42% of PLWH were infected by male-to-male sex. Heterosexual contact accounted for 10% of new diagnoses and 17% of PLWH. Perinatal infection accounts for less than 1% of all HIV transmissions. In Mississippi, more than one third of HIV cases are not identified by transmission category.

The Jackson MSA is similarly distributed. Approximately 39% of PLWH have no transmission category reported.

Table A.11
HIV/AIDS by Transmission Category
State of Mississippi and Jackson MSA 2014

	New Dx		PLWH	
	Cases	**%**	**Cases**	**%**
Male-to-male sex (MSM)	282	58.3%	3,727	39.4%
Injection Drug Use (IDU)	*	0.4%	425	4.5%
Male-male sex and IDU	*	0.4%	267	2.8%
Heterosexual contact	46	9.5%	1,628	17.2%
Perinatal exposure	0	0.0%	70	0.7%
Other/Unknown	152	31.4%	3,339	35.3%
Total	484	100.0%	9,456	100.0%
Jackson MSA				
Male-to-male sex (MSM)	91	53.2%	1,329	36.9%
Injection Drug Use (IDU)	0	0.0%	179	5.0%
Male-male sex and IDU	0	0.0%	104	2.9%
Heterosexual contact	12	7.0%	555	15.4%
Perinatal exposure	*	0.6%	30	0.8%
Other/Unknown	28	16.4%	1,407	39.0%
Total	171	100.0%	3,604	100.0%

Note: Quantities less than five are not reported.

The Burden of HIV/AIDS in Mississippi

Reflective of the HIV/AIDS profile, the burden of HIV emerges from recent trends, as shown below. It shows an epidemic that has not abated with a clear emphasis on Black MSM as the population with greatest risk and increasing significance.

From 2010 through 2014, the number of persons living with HIV/AIDS increased 13.7% largely as a function of persons living longer from improved and effective treatment. However, new diagnoses increased 4.8% over the past five years, approximately 1% per year, evidence that the epidemic continues. Both incidence and prevalence rates have increased.

Table A.12
Prevalence and Incidence of HIV/AIDS
State of Mississippi 2010-2014

	2010	**2011**	**2012**	**2013**	**2014**
New Dx	462	533	447	479	484
Rate	15.6	17.9	15.0	16.0	16.2
PLWH	8,320	8,632	8,887	9,143	9,456
Rate	280.1	289.8	297.7	305.7	316.9

In Jackson MSA, increasing incidence cases and rates are most notable in Hinds County where new diagnoses average 116 per year and rates range from 41.0 to 51.9.

Table A.13
Jackson MSA Five-County Area
New Diagnoses 2010-2014

	2010		2011		2012		2013		2014	
	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
Copiah County	5	17.0	6	20.5	7	24.2	6	21.0	10	34.7
Hinds County	114	46.5	117	47.1	129	51.9	101	41.0	118	48.4
Madison County	5	5.3	10	10.3	14	14.2	15	15.0	19	18.7
Rankin County	28	19.8	38	26.4	23	15.8	29	20.0	22	14.9
Simpson County	*	7.3	*	11	*	11	*	15.0	*	3.6

Note: Quantities less than five are not reported.

Gender

The percentage of male diagnoses has ranged from 75% to 80% in five years 2010 to 2014. Year 2012 had the largest male cohort, but this gender has clearly dominated the epidemic throughout the decade. Data to quantify the transgender population are not available.

Table A.14
New HIV/AIDS Diagnoses by Gender 2010-2014

	2010	2011	2012	2013	2014	Total
Female	24.7%	26.1%	19.7%	24.6%	22.7%	28.3%
Male	75.3%	73.9%	80.3%	75.4%	77.3%	71.7%

Age

From 2010 to 2014, new HIV diagnoses increased for age cohorts 13-24 and 25-34. The percentage representation of these two cohorts increased as well.

It should be noted that older PLWH (age 55+) declined in number and percent, which is contrary to national trends and longer life expectancy. From 2010 to 2014, PLWH age 55+ declined by 115 or 10% overall. During this same period, the number and percent of those 13-24 grew 39% and those 25-34 grew by 50%.

Table A.15
New HIV/AIDS Diagnoses by Age Cohort 2010-2014

	2010		2011		2012		2013		2014		Change 2010-2014	
Current age (yrs)	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**No.**	**%**
<13	*	0.2%	0	0.0%	*	0.2%	*	0.4%	0	0.0%	-1	0.2%
13 to 24	127	27.5%	159	29.8%	143	32.0%	158	33.0%	153	31.6%	26	4.1%
25-34	123	26.6%	144	27.0%	126	28.2%	130	27.1%	165	34.1%	42	7.5%
35-44	101	21.9%	95	17.8%	70	15.7%	89	18.6%	67	13.8%	-34	-8.0%
45-54	75	16.2%	83	15.6%	60	13.4%	52	10.9%	59	12.2%	-16	-4.0%
55+	35	7.6%	52	9.8%	47	0.2%	48	10.0%	40	8.3%	5	0.7%

Table A.16
Persons Living with HIV/AIDS by Age Cohort 2010-2014

	2010		2011		2012		2013		2014		Change 2010-2014	
Current age (yrs)	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**No.**	**%**
<13	10	0.1%	10	0.1%	11	0.1%	13	0.1%	13	0.1%	3	0.3%
13 to 24	149	1.8%	226	2.6%	323	3.6%	451	4.9%	587	6.2%	438	38.6%
25-34	1,292	15.5%	1,458	16.9%	1,588	17.9%	1,711	18.7%	1,862	19.7%	570	50.2%
35-44	2,043	24.6%	2,119	24.5%	2,158	24.3%	2,210	24.2%	2,248	23.8%	205	18.0%
45-54	2,803	33.7%	2,827	32.8%	2,832	31.9%	2,825	30.9%	2,838	30.0%	35	3.1%
55+	2,023	24.3%	1,992	23.1%	1,975	22.2%	1,933	21.1%	1,908	20.2%	-115	-10.1%

Race/Ethnicity

The predominance of Black race/ethnicity remained consistent from 2010-2014. This is true of newly diagnosed and PLWH. Black PLWH increased 0.7% over the five-year period.

Table A.17
New HIV/AIDS Diagnoses by Race/Ethnicity 2010-2014

	2010		2011		2012		2013		2014	Change 2010-2014		
Race/Ethnicity	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**No.**	**%**
Hispanic, All races	12	2.6%	16	3.0%	10	2.2%	12	2.5%	14	2.9%	2	0.3%
American Indian/Alaska Native, Not Hispanic	0	0.0%	*	0.0%	*	0.2%	0	0.0%	0	0.0%	0	0.0%
Asian, Not Hispanic	0	0.0%	*	0.2%	*	0.2%	*	0.4%	*	0.2%	*	0.2%
Black, Not Hispanic	360	77.9%	409	76.7%	342	76.5%	370	77.2%	380	78.5%	20	0.6%
Native Hawaiian/Pacific Islander, Not Hispanic	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
White, Not Hispanic	66	14.3%	84	15.8%	77	17.2%	72	15.0%	79	16.3%	13	2.0%
Multiple Race, Not Hispanic	24	5.2%	23	4.3%	16	3.6%	23	4.8%	10	2.1%	(14)	-3.1%

Note: Quantities less than five are not reported.

Table A.18
PLWH by Race/Ethnicity 2010-2014

	2010		2011		2012		2013		2014		Change 2010-2014	
Race/Ethnicity	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Hispanic, All Races	182	2.2%	196	2.3%	200	2.3%	208	2.3%	219	2.3%	37	0.1%
American Indian/Alaska Native, Not Hispanic	11	0.1%	10	0.1%	11	0.1%	9	0.1%	8	0.1%	(3)	0.0%
Asian, Not Hispanic	12	0.1%	12	0.1%	13	0.1%	14	0.2%	15	0.2%	3	0.0%
Black, Not Hispanic	6,119	73.5%	6,361	73.7%	6,560	73.8%	6,765	74.0%	7,016	74.2%	897	0.7%
Native Hawaiian/ Pacific Islander, Not Hispanic	*	0.0%	1	0.0%	1	0.0%	1	0.0%	1	0.0%	0	0.0%
White, Not Hispanic	1,749	21.0%	1,787	20.7%	1,822	20.5%	1,855	20.3%	1,900	20.1%	151	-0.9%
Multiple Race, Not Hispanic	212	2.5%	231	2.7%	246	2.8%	258	2.8%	264	2.8%	52	0.2%

Note: Quantities less than five are not reported.

Transmission Category

Male-to-male sex (MSM) increased by 79 new diagnoses from 2010 to 2014 or 14%. Heterosexual contact was the only other transmission category that witnessed an increase (1.7%) during this time period. Among persons living with HIV/AIDS, MSM also increased in number and percentage, from 2,886 to 3,727 an increase of 841 new diagnoses or 4.7%.

Table A.19
New HIV/AIDS Diagnoses by Transmission Category 2010-2014

	2010		2011		2012		2013		2014		Change	
	#	%	#	%	#	%	#	%	#	%	#	%
Male-to-male sex	203	43.9%	253	47.5%	255	57.0%	249	52.0%	282	58.3%	79	14.3%
Injection Drug Use (IDU)	13	2.8%	9	1.7%	6	1.3%	8	1.7%	2	0.4%	-11	-2.4%
Male-male sex and IDU	14	3.0%	5	0.9%	2	0.4%	2	0.4%	2	0.4%	-12	-2.6%
Heterosexual contact	36	7.8%	82	15.4%	83	18.6%	0	20.9%	46	9.5%	10	1.7%
Perinatal exposure	1	0.2%	0	0.0%	1	0.2%	1	0.2%	0	0.0%	-1	-0.2%
Other/ Unknown	195	42.2%	184	34.5%	100	22.4%	19	24.8%	52	31.4%	-43	10.8%
Total	462	100.0%	533	100.0%	447	100.%	479	100.0%	484	100.0%	22	0.0%

Table A.20
PLWH by Transmission Category
2010-2014

	2010		2011		2012		2013		2014		Change	
	#	%	#	%	#	%	#	%	#	%	#	%
Male-to-male sex	2,886	34.7%	3,081	35.7%	3,297	37.1%	3,487	38.1%	3,727	39.4%	841	29.1%
Injection Drug Use (IDU)	471	5.7%	457	5.3%	442	5.0%	436	4.8%	425	4.5%	-46	-1.2%
Male-male sex and IDU	285	3.4%	284	3.3%	281	3.2%	270	3.0%	267	2.8%	-18	-0.6%
Heterosexual contact	1,475	17.7%	1,515	17.6%	1,550	17.4%	1,606	17.6%	1,628	17.2%	153	-0.5%
Perinatal exposure	71	0.9%	70	0.8%	70	0.8%	70	0.8%	70	0.7%	-1	-0.1%
Other/ Unknown	3,132	37.6%	3,225	37.4%	3,247	36.5%	3,274	35.8%	3,339	35.3%	207	-2.3%
Total	8,320	100.0%	8,632	100.0%	8,887	100.0%	9,143	100.0%	9,456	100.0%	1,136	0.0%

Acuity and Co-Morbidity

Mississippi State Department of Health reports HIV disease cases with either persons diagnosed with HIV or concurrent diagnosis of AIDS. In 2013, 45.6% of persons living with HIV/AIDS were diagnosed with Stage 3 (AIDS) infection (4,284 out of 9,398). This compares favorably to 2014 national average of 45.6% with Stage 3 (AIDS) infection.

The Centers for Disease Control reports Mississippi chlamydia and gonorrhea infections rates among the highest in the nation. Primary and secondary syphilis rates are also high and approach the 75th percentile. In 2014, MSDH reported 19,603 cases of chlamydia, 5,629 of gonorrhea and 531 of syphilis.

- Chlamydia cases were highest in District 5 with 4,927 reported cases. Infection rates were especially high in District 3 with 1,162.2 cases per 100,000 population. Jackson MSA (685.6/100,000) ranked just below District 5 and above the statewide average case rate (654.7).
- Similarly, gonorrhea cases were highest in District 5 with 1,666 reported cases. Infection rates were highest in District 3 with 268.9 cases per 100,000 population. Jackson MSA (227.1/100,000) ranked just below District 5 and above the statewide average case rate (188.0).
- Syphilis cases and rates, inclusive of primary and secondary and early latent, were highest in District 5 (232 cases and 36.2/100,000) and Jackson MSA (227 cases and 39.5/100,000). Syphilis is often associated with HIV Infection, as demonstrated by high rates in the HIV epicenter.

Table A.21
Sexually Transmitted Infection Cases and Rates
Health Districts, Jackson MSA and Mississippi
2014

	Chlamydia		Gonorrhea		Primary and Secondary Syphilis		Early Latent Syphilis	
	#	Rate	#	Rate	#	Rate	#	Rate
District 1	2,141	658.1	378	116.2	11	3.4	25	7.7
District 2	1,829	494.9	395	106.9	4	1.1	21	5.7
District 3	2,425	1162.2	561	268.9	6	2.9	25	12
District 4	1,559	635.6	445	181.4	16	6.5	19	7.7
District 5	4,927	769.0	1,666	260.0	76	11.9	156	24.3
District 6	1,582	653.9	509	210.4	12	5	8	3.3
District 7	1,166	681.1	302	176.4	14	8.2	5	2.9
District 8	1,762	570.4	679	219.8	34	11	32	10.4
District 9	2,212	458.4	694	143.8	19	3.9	48	9.9
Jackson MSA	3,942	685.6	1,306	227.1	227	39.5	227	39.5
Mississippi	19,603	654.7	5,629	188.0	192	6.4	339	11.3

Note: Syphilis data for Jackson MSA include both primary and secondary, early latent disease stages.

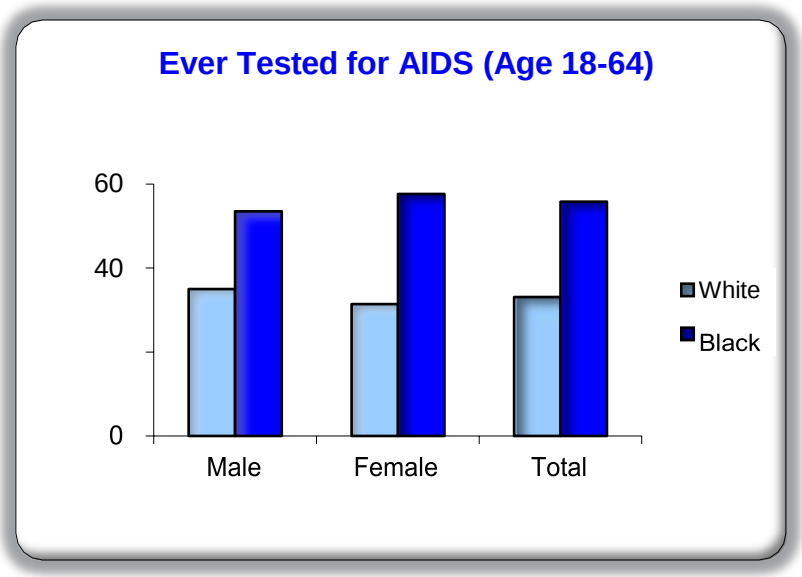
STI co-infection with HIV is not captured in the Mississippi surveillance registry. Tuberculosis co-morbidity was definitively identified in one new HIV/AIDS diagnosis in 2014. Hepatitis co-infection is also not captured in the surveillance registry. However, 30 patients treated at Part B clinics received medications for Hepatitis C.

Indicators of HIV Risk

Behavioral Risk Factors

Latest reports from the Mississippi Behavioral Risk Factor Surveillance Survey are from 2013. One question about HIV/AIDS was asked of persons between ages 18 and 64. When asked whether the respondent had ever been tested for the AIDS virus, 41.4% answered 'yes.' Black respondents were more likely to have been tested than Whites (55.8% vs 33.1%). Similarly, testing rates were higher for males (35.0%) than females (31.3%). Within the Black population, rates were higher for females (57.6%) than males (53.5%).[10]

Figure A.6
BRFSS Survey Data 2013 by Gender and Race[11]



[10] State of Mississippi, Mississippi Behavioral Risk Factor Surveillance Survey 2013 Prevalence Report http://www.msdh.ms.gov/brfss/brfss2013ar.pdf. 68-69.
[11] Ibid.

Table A.22
BRFSS Survey Data 2013
Ever Tested for HIV[12]

Groups	White		Black		Total	
	Number [1]	Percent [2]	Number [1]	Percent [2]	Number [1]	Percent [2]
Sex						
Male	452	35.0	299	53.5	769	41.0
Female	586	31.3	707	57.6	1,320	41.9
Age Group						
18-24	55	28.3	75	57.8	134	41.7
25-34	171	59.8	199	80.0	377	68.2
35-44	197	51.3	214	76.7	423	61.0
45-54	239	38.4	217	49.7	464	42.2
55-64	201	21.9	180	36.0	388	26.4
Education						
< High School Graduate	105	30.3	180	44.2	293	37.2
High School Graduate or GED	250	28.3	317	55.0	578	39.2
Some College or Technical School	312	36.5	251	60.6	572	43.9
College Graduate	371	36.1	258	69.2	646	45.5
Income						
< $15,000	159	43.5	302	56.1	472	50.8
$15-$24,999	163	35.4	247	56.8	422	46.3
$25-$34,999	104	32.4	107	48.7	216	38.4
$35-$49,999	127	33.8	92	50.9	221	38.6
$50-$74,999	134	29.4	76	73.5	213	37.7
$75,000+	244	34.5	82	70.6	330	39.4
Employment Status						
Employed	563	39.2	496	62.2	1,080	47.0
Not Employed	70	53.2	124	71.5	200	62.8
Student/Homemaker	79	26.2	65	54.9	153	37.5
Retired/Unable to Work	326	21.2	319	39.9	654	28.0
Total	1,038	33.1	1,006	55.8	2,089	41.4

[1] *Unweighted*
[2] *Weighted*

[12] State of Mississippi, Mississippi Behavioral Risk Factor Surveillance Survey 2013 Prevalence Report http://www.msdh.ms.gov/brfss/brfss2013ar.pdf. 68-69

Youth Behavioral Risk Factors

As attention mounts toward preventing HIV/AIDS among youth, recent data show increasing use of injecting and other illicit drug use, and somewhat diminished sexual activity. [13]

- In 2015, youth reporting using cocaine, ecstasy or heroin increased an average of 2.8 percentage points since 2011. In 2015, 5.4% of youth ever injected any illegal drug using a needle, up from 2.5% in 2011. Prescription drug use also increased. Drug sales to youth increased from 16% to 24% in 2015.
- Forty-eight percent of youth reported ever having sexual intercourse, down from 58% in 2011. Youth who reported having sex with multiple partners declined from 22% in 2011 to 15.5% in 2015. Condom usage increased from 35% to 44%, evidence of more careful attitudes toward sexual activities.

Table A.23
Alcohol and Other Drug Use and Sexual Behaviors Among Youth 2011 and 2015.
Youth Behavioral Risk Factor Surveillance Survey

Alcohol and Other Drug Use	2011	2015	Change
Ever used synthetic marijuana (also called "K2", "Spice", "fake weed", "King Kong", "Yucatan Fire", "Skunk", or "Moon Rocks", one or more times during their life)	N/A	9.7%	N/A
Ever used cocaine (any form of cocaine, such as powder, crack, or freebase, one or more times during their life)	4.3%	6.5%	2.2%
Ever used ecstasy (also called "MDMA," one or more times during their life)	5.3%	7.8%	2.5%
Ever used heroin (also called "smack," "junk," or "China white," one or more times during their life)	2.3%	5.9%	3.6%
Ever used methamphetamines (also called "speed," "crystal," "crank," or "ice," one or more times during their life)	3.0%	6.0%	3.0%
Ever took steroids without a doctor's prescription (pills or shots, one or more times during their life)	4.2%	6.3%	2.1%
Ever took prescription drugs without a doctor's prescription (such as Oxycontin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life)	15.7%	17.2%	1.5%
Ever used inhalants (sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high, one or more times during their life)	11.0%	11.6%	0.6%
Ever injected any illegal drug (used a needle to inject any illegal drug into their body one or more times during their life)	2.5%	5.4%	2.9%
Were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	15.9%	23.7%	7.8%
Source: CDC Youth BRFSS Survey, https://nccd.cdc.gov/Youthonline/App/Default.aspx			

(Table continues)

[13] Centers for Disease Control Youth BRFSS Survey 2015, https://nccd.cdc.gov/Youthonline/App/Default.aspx.

Sexual Behaviors	2011	2015	Change
Ever had sexual intercourse	57.9%	48.0%	-9.9%
Had sexual intercourse before age 13 years (for the first time)	11.8%	8.3%	-3.5%
Had sexual intercourse with four or more persons (during their life)	22.1%	15.5%	-6.6%
Were currently sexually active (had sexual intercourse with at least one person during the 3 months before the survey)	42.1%	33.8%	-8.3%
Did not use a condom (during last sexual intercourse, among students who were currently sexually active)	35.4%	44.2%	8.8%
Did not use birth control pills; an IUD or implant; or a shot, patch, or birth control ring (before last sexual intercourse to prevent pregnancy, among students who were currently sexually active)	79.8%	70.5%	-9.3%
Did not use both a condom during and birth control pills; an IUD or implant; or a shot, patch, or birth control ring (before last sexual intercourse to prevent pregnancy, among students who were currently sexually active)	92.0%	89.9%	-2.1%
Did not use any method to prevent pregnancy (during last sexual intercourse, among students who were currently sexually active)	10.9%	14.8%	3.9%
Drank alcohol or used drugs (before last sexual intercourse, among students who were currently sexually active)	18.8%	17.4%	-1.4%
Source: CDC Youth BRFSS Survey, https://nccd.cdc.gov/Youthonline/App/Default.aspx			

HIV Testing Program Data

The Mississippi Department of Health HIV/STD Office reported a total of 78,210 HIV test events taken in 2014. Of them, 833 new and 148 previously identified tests were found to be HIV-positive. Sixty-three percent of the newly confirmed were identified as MSM. Twenty-two percent of tests newly confirmed were from individuals infected by heterosexual contact.

Table A.24
HIV Testing in Mississippi, 2014

	HIV Tests	Positive Tests	Newly Identified Positive	Newly Identified Positive Linked to Care	Newly Confirmed Positive	Newly Confirmed + PS Interview	Newly Confirmed + HIV Prevention Services	Previously Identified Positive	Previously Identified Positive + Linked to Care	Previously Confirmed	Previously Confirmed + PS Interview	Previously Confirmed + HIV Prevention
Race												
Black	54,182	525	444	344	417	312	322	81	19	72	10	12
White	19,169	137	114	83	109	81	82	23	12	17	3	5
Hispanic	443	166	124	104	122	92	102	41	6	39	4	4
Other	4,859	5	3	3	3	3	3	3	1	2	0	0
Gender												
Male	28,368	651	536	423	507	382	400	114	25	102	12	13
Female	49,242	175	144	109	139	104	107	31	12	25	4	7
Age Group												
0-12	222	0	0	0	0	0	0	0	0	0	0	0
13-19	10,469	38	36	30	35	28	29	2	2	1	1	1
20-39	54,301	522	449	369	422	333	350	72	18	65	7	9
40-59	11,535	246	179	118	173	111	114	67	12	60	6	8
60+	1,665	8	21	17	21	16	16	7	6	4	3	3
Total	**78,210**	**833**	**685**	**534**	**651**	**507**	**509**	**148**	**38**	**130**	**17**	**21**

Table A.25
Newly Identified Positive Tests, 2014

Risk Category	Total	Percent
MSM	410	59.85
Low-risk heterosexual contact	140	20.44
Unknown	87	12.7
High-risk heterosexual contact	27	3.94
IDU	9	1.31
MSM/IDU	7	1.02
Low-risk sex with transgender or female to female contact	5	0.73

Source: MSHD

RWHAP Program Data

Data were available for the eight Part B sub-recipients, two of which are also funded under Part C and one under Part D, and to state-operated facilities. The profile reflects a client population that is largely minority, in poverty and without sufficient insurance coverage.

- The Part B Program reported 2,387 clients in 2015 whose demographics largely reflect the statewide epidemic. Part B clients are 75% male, 78% Black and 76% age 25-54.
- Eighty-five percent of Part B clients live at or below 200% of the federal poverty level.
- Few Part B clients have insurance coverage of any type. Eighty-two percent were uninsured. 14% reported having some form of private insurance, and 13.8% Medicaid covered just 5% of the Part B clients, and 11% were enrolled in Medicare Part A, B or D.

Table A.26
RWHAP Part B Client Profile 2015

	#	%
Total	2,387	100.00%
Gender		
Female	592	24.8%
Male	1,786	74.8%
Transgender	9	0.4%
Race/Ethnicity		
White	503	21.1%
Black	1,870	78.3%
Asian/Pacific Islander/Other	14	0.6%
Hispanic	52	2.2%
Age		
0-24	274	11.5%
25-34	708	29.7%
35-44	563	23.6%
45-54	546	22.9%
55+	296	12.4%
Income Below Federal Poverty Level		
100% Below FPL	1,298	54.4%
101-200% Below FPL	722	30.2%
201-500% Below FPL	179	7.5%
Unknown	188	7.9%

(Table continues)

	#	%
Medical Insurance [a]		
Private - Employer	174	7.3%
Private - Individual	155	6.5%
Medicare Part A/B	157	6.6%
Medicare Part D	103	4.3%
Medicaid, CHIP or other public plan	129	5.4%
VA, Tricare and other military health care	1	0.0%
HIS	2	0.1%
Other plan	110	4.6%
No insurance/uninsured	1,949	81.7%
Not identified	166	7.0%
a May be insured by more than one payer.		

ADAP

In 2015, 2,184 individuals were enrolled in the AIDS Drug Assistance Program (ADAP). Data were available by gender and race/ethnicity for each District.

- Thirty-eight percent of ADAP enrollees were from District 5, where Jackson MSA is located. District 9, with the second largest number of enrollees was a distant 13%.
- Gender and race demographic distributions did not differ significantly from the Part B Profile. Females, though always fewer than males, reached 35% in District 1 and 31% in District 5. It may also be noted that the majority of White enrollees were located in Districts 2 and 9.

Table A.27
ADAP Enrollees by Gender and Race/Ethnicity 2015

	Female		Male		Total	
	#	%	#	%	#	%
District1	55	35.3%	101	64.7%	156	100.0%
District 2	30	21.9%	107	78.1%	137	100.0%
District 3	36	19.6%	148	80.4%	184	100.0%
District 4	30	23.6%	97	76.4%	127	100.0%
District 5	211	25.8%	606	74.2%	817	100.0%
District 6	40	30.5%	91	69.5%	131	100.0%
District 7	26	25.7%	75	74.3%	101	100.0%
District 8	53	22.4%	184	77.6%	237	100.0%
District 9	70	24.3%	218	75.7%	288	100.0%
Mississippi	551	25.3%	1,627	74.7%	2,178	100.0%

	White		Black		Hispanic		Other	
	#	%	#	%	#	%	#	%
District1	21	13.5%	131	84.0%	3	1.9%	1	0.6%
District 2	53	38.7%	79	57.7%	5	3.6%	0	0.0%
District 3	10	5.4%	171	92.9%	3	1.6%	0	0.0%
District 4	28	22.0%	99	78.0%	0	0.0%	0	0.0%
District 5	89	10.8%	721	87.6%	10	1.2%	3	0.4%
District 6	27	20.3%	99	74.4%	3	2.3%	4	3.0%
District 7	19	18.8%	80	79.2%	2	2.0%	0	0.0%
District 8	55	23.4%	175	74.5%	5	2.1%	0	0.0%
District 9	117	40.6%	149	51.7%	16	5.6%	6	2.1%
Mississippi	419	19.2%	1704	78.0%	47	2.2%	14	0.6%

Co-Morbidity Data

Please refer to page 35 above.

Vital Statistics

Deaths due to AIDS are reported in vital statistics maintained by MSDH. Please refer to page 23 for additional information. MSDH also reported no deaths to HIV-positive pregnant women or their newborns in 2013, 2014 or 2015.

Other Relevant Qualitative Data

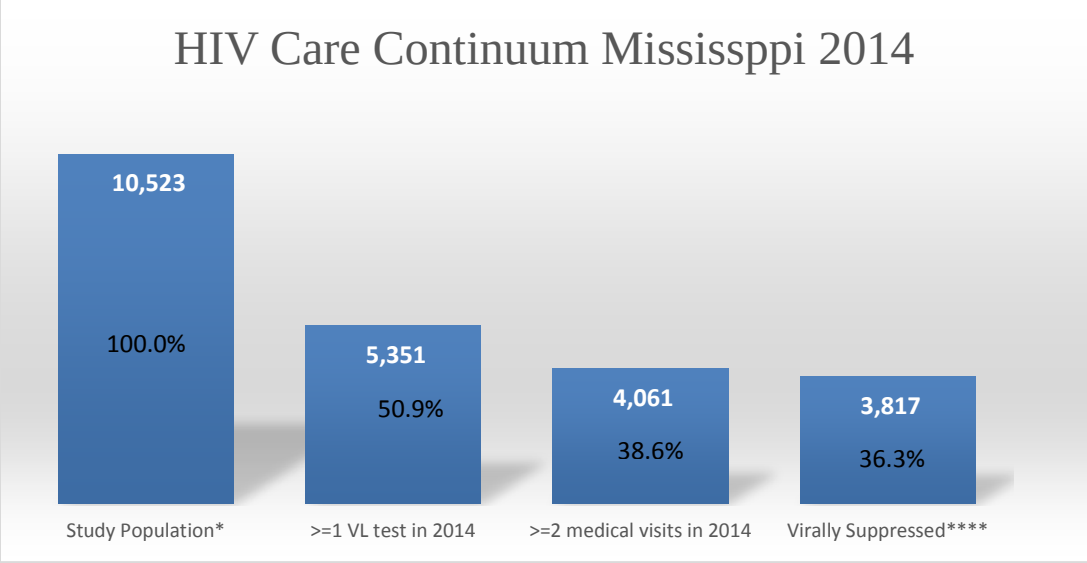
NOTE: This section follows on Page 49, after HIV CARE CONTINUUM

B. HIV CARE CONTINUUM

The Diagnosis-Based HIV Continuum

As of December 31, 2014, 10,523 individuals were diagnosed and living with HIV infection. According to Mississippi Department of Health HIV/STD Office, 5,351 or 55.5% received one or more viral load tests during the calendar year.[14] PLWH retained in care totaled 4,061 or 38.6% of the study population, and 3,817 (36.3%) were considered virally suppressed during the same calendar year.[15] Prescriptions of antiretroviral therapy are not maintained by this source. Further, as depicted in the HIV Care Continuum, 75.9% of those who received a viral load test in 2014 were retained in care and, of them, 94.0% were also virally suppressed. (Figure B.1)

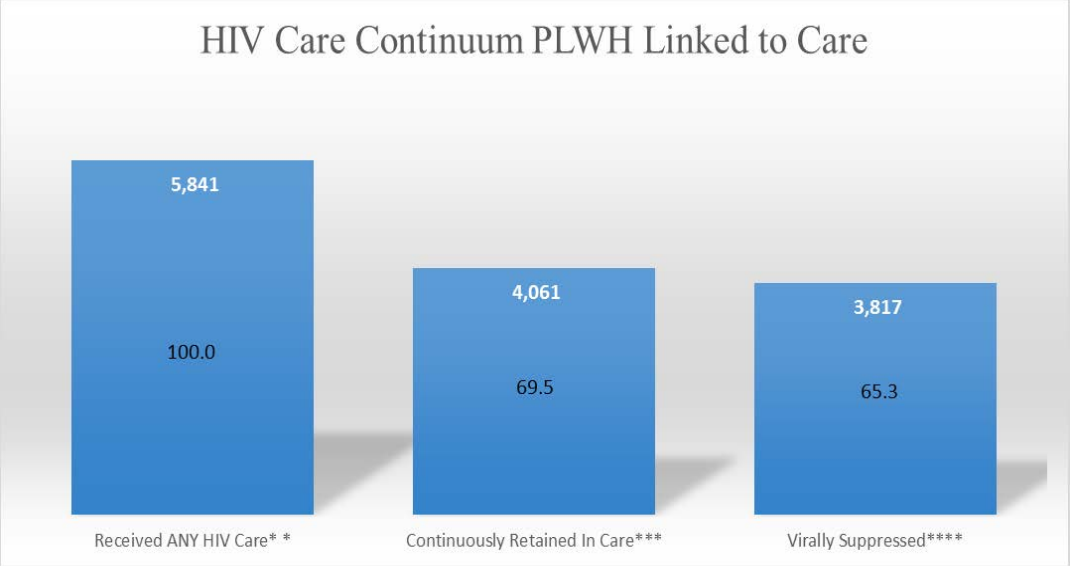
Figure B.1
HIV Care Continuum All PLWH 2014



[14] Persons who had at least one CD4 or viral load or HIV-1 genotype test were considered as having received medical care. "Linked to care" is measured by one or more medical visit. "Retained in care" is measured by two or more medical visits at least 90 days apart.
[15] Viral suppression is defined as a viral load test result <200 copies/mL during the 2014 calendar year.

When using linkage to care as the baseline measure, the HIV Care Continuum is altered somewhat. Of the 5,841 persons linked to care with a medical visit, 4,061 (69.6%) were retained with two or more visits. Viral suppression was reached by 65.3% of those linked to care. (See Figure B.2)

Figure B.2
HIV Care Continuum PLWH Linked to Care



Disparities in Engagement Among Key Populations Along the HIV Care Continuum

Across the various population categories, suppression rates (counting those with at least one viral load test) varied, ranging from 57.5% to 77.7%. The average suppression rate for Mississippi in 2014 was 71.3%.

- Males achieved higher suppression rates than females (73.2% vs 68.2%).
- Suppression rates increased with age from 57.5% among age 13-24 to 82.6% for those age 65+.
- Black suppression rates (69.1%) were lowest of the race/ethnicities.
- Viral suppression across transmission categories also varied from 70.7% for heterosexual contact to 77.7% for MSM/IDU. MSM viral suppression rates in 2014 totaled 72.3%, slightly above the average.
- PLWH infected through heterosexual contact averaged 75.0% for males and 69.2% for females.

Populations with below average suppression rates (71%) include females (68.2%), individuals age 13-44 (66.4%), and Other/Unknown Transmission Category (59.4%).

Table B.1
Viral Suppression by Population Category

Characteristics	No. of persons diagnosed with HIV infection through 12/31/2013 and living with HIV on 12/31/2014 (overall population)[f]	No. of persons with >=1 VL test between 01/01/2014 through 12/31/2014	No. of persons who have >=2 care visits between 01/01/2014 through 12/31/2014, at least 91 days apart	No. of persons with HIV viral suppression	% of persons with HIV viral suppression among the overall population	% of persons with HIV viral suppression among persons with >=1 VL test between 01/01/2014 through 12/31/2014
Sex						
Male	6,768	3,364	2,565	2,461	36.36	73.16
Female	3,755	1,987	1,496	1,356	36.11	68.24
Age on 12/31/2013						
13-24	655	398	293	229	34.96	57.54
25-34	2,058	1,078	786	700	34.01	64.94
35-44	2,786	1,425	1,060	997	35.79	69.96
45-54	3,140	1,522	1,187	1,160	36.94	76.22
55-64	1,494	738	581	574	38.42	77.78
>=65	390	190	154	157	40.26	82.63
Race/ethnicity						
Black	7,648	4,014	3,062	2,773	36.26	69.08
White	2,194	966	711	759	34.59	78.57
Hispanic/Latino[b]	304	134	104	102	33.55	76.12
Other/Unknown Races	377	237	184	183	48.5%	77.22%
Transmission category						
Male-to-male sexual contact (MSM)	3,790	1,991	1,520	1,439	37.97	72.28
Injection drug use (IDU)	566	257	188	188	33.22	73.15
MSM and IDU	364	148	111	115	31.59	77.7
Heterosexual contact[c]	2,067	1,147	827	811	39.24	70.71
NIR/NRR (unknown)	3,631	1,744	1,363	1,226	33.76	70.3
Other[d]	105	64	52	38	36.19	59.38
Total	**10,523**	**5,351**	**4,061**	**3,817**	**36.27**	**71.33**

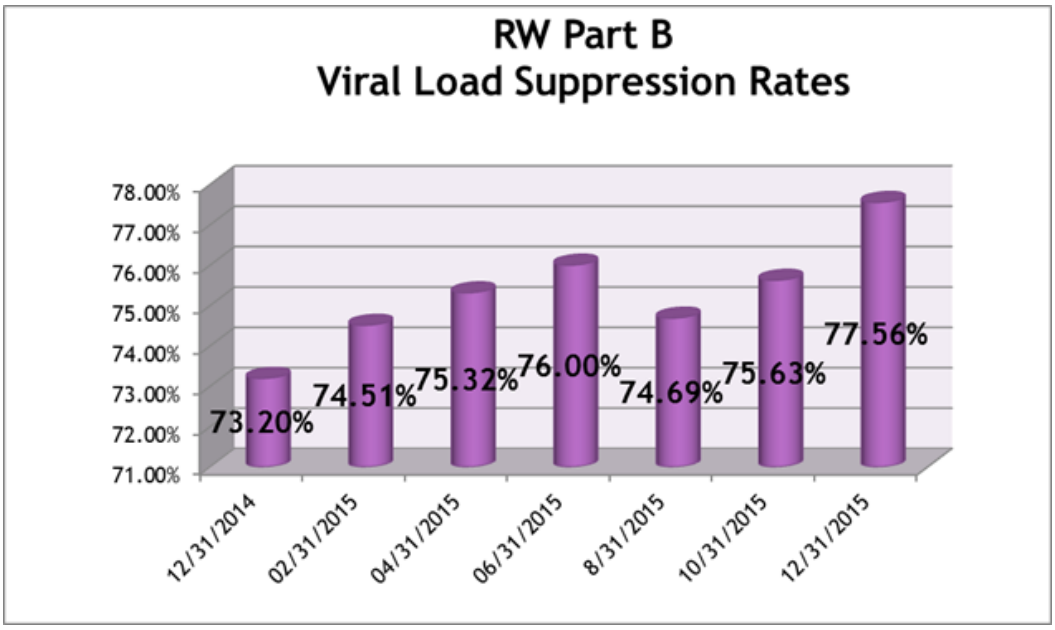
[a]Includes Asian/Pacific Islander legacy cases.
[b]Hispanics/Latinos can be of any race.
[c]Heterosexual contact with person known to have, or to be at high risk for, HIV infection.
[d]Includes hemophilia, blood transfusion, and persons (77 cases) who were exposed perinatally but were aged > 13 at most recent year.
[e]Persons who had a viral load test result <200 copies/ml between 01/01/2014 through 12/31/2014 are considered as having a suppressed viral load.
[f]The overall population is overestimated because cases are only followed up for 16 months after 12/31/2014. CDC suggests that every case should be followed up at least 18 months to collect death certificate information.

How the HIV Care Continuum is Currently Used

Mississippi Department of Health HIV/STD Office constructs and analyzes the HIV Care Continuum annually and distributes the results to all users of surveillance data for the purpose of planning and quality improvement. Presently, the HIV Care Continuum functions as a stepping-off point to identify and focus improvement efforts at the clinical level. The Continuum was first presented to the Community Planning Group to begin the conversation about improving measures of care. The process is ongoing.

In a tangible effort to affect the Health Care Continuum, MSHD initially focused on improving viral load suppression as its first priority. Quality improvement efforts led to a rise in the suppression rate from 73.2% in 2014 to 77.6% in 2015.

Figure B.3
Viral Suppression Rates 2014-2015



MSDH participates in the National Quality Center's HIV Cross-Part Care Continuum Cross Collaborative (H4C) that focuses on increasing viral load suppression through analysis and use of the HIV Care Continuum. Begun in 2014, five states were selected based on their potential to increase viral suppression at RWHAP-funded clinics. Mississippi successfully completed the requirements of the H4C, constructed a diagnosis-based HCC and instituted improvement processes that increased its data collection capacity as well as achieved a higher viral suppression rate. Four quality indicators, chosen to support measurement of viral suppression, linkage, retention and ARV therapies, were monitored bi-monthly and results communicated to H4C as well as seven reporting clinics in Mississippi. Results through April 2016 indicate 78% viral suppression, 94% use of ARV therapies, a 65% retention rate and 17% failure to link into care within the first six months of diagnosis.

Figure B.4
H4C/HAB Quality Indicators 2014-2015

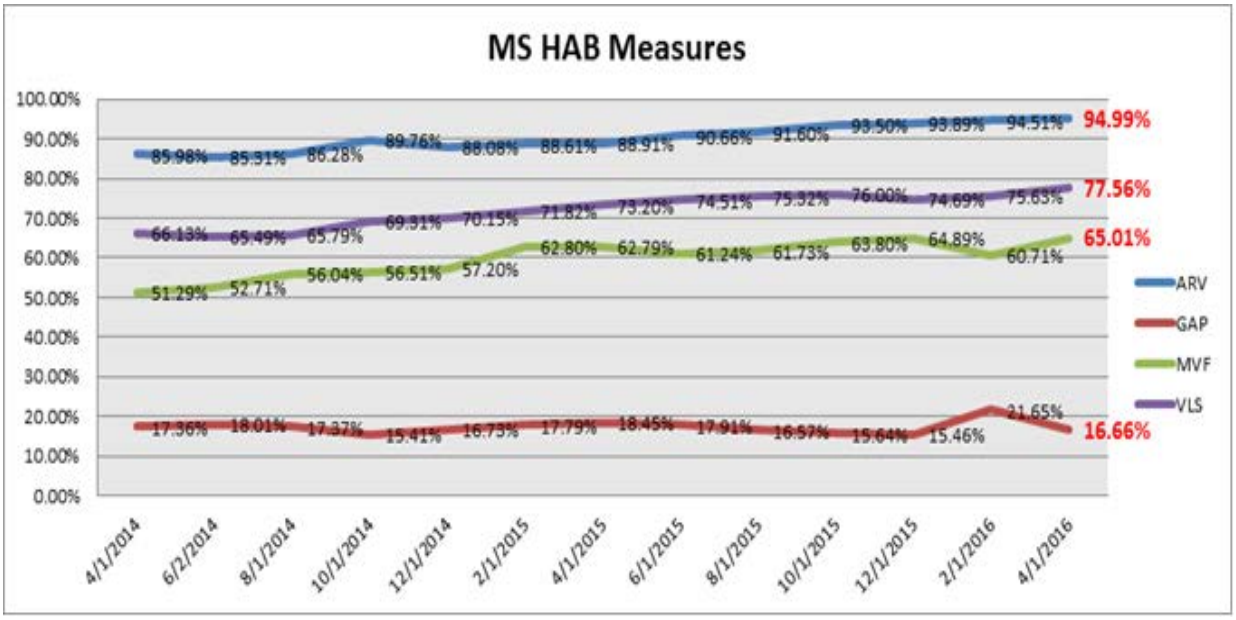


Table B.2
H4C Quality Indicators
State of Mississippi 2016

Indicator	As of April 2016
HIV Viral Load Suppression	77.56%
Rx of ARV Therapies	94.11%
HIV Medical Visit Frequency	65.01%
Gaps in HIV Medical Visits	16.66%

Source: MSHD H4C bi-monthly reports

MSHD constructs a variation of the Health Care Continuum for each of its Part B clinics as an analytic tool to strengthen performance improvement leading to viral load suppression. These tools help to identify high performers and to develop strategies to shift resources by identifying providers where quality measures are below par.

The Continuum also will be used to bolster prevention efforts. Plans are to construct the continuum to reflect demographic variables and, if feasible, populations at risk. This information will help target outreach toward more fruitful results.

Mississippi Department of Health HIV/STD Office has moved to improve its surveillance data collection system, particularly with regard to CD4 and viral load lab results, used for estimating unmet need. The HIV Care Continuum provides the most accurate representation available for determining unmet need, i.e., the difference between persons diagnosed and persons who received a viral load test in a given year. MSDH is currently receiving technical assistance from GEARS, Inc., a consulting group working with the Centers for Disease Control and Prevention, to identify ways to use linkage-to-care data. For example, out-of-care lists are being developed to identify PLWH without recorded CD4 or viral load tests. Social workers are trained to utilize the lists to find and re-engage the out-of-care.

Other Relevant Qualitative Data

In addition to quantitative data, qualitative information gathered from focus groups, key informant interviews, a consumer survey, and interviews with out-of-care consumers serves to inform and augment the epidemiologic information and provides insights into important issues that impact the State's efforts to prevent the spread of HIV infections.

Emerging Populations and Issues

There is a strong sense among focus group participants and key informants that the State's policy of teaching teens abstinence or abstinence plus does not adequately prepare them to deal with the pressure of adolescence and with the explicit sexual messaging that goes on around them in the media; in music, advertising, and most forms of entertainment. This lack of information about sex impacts teens' ability and knowledge of how to protect themselves against HIV, STDs and unwanted pregnancies, all of which exceed U.S. averages.

Many report an increase in the number of young Black MSMs in the last year. Other concerns raised by HIV professionals is the cavalier and nonchalant attitude of young people who, having grown up in an era of antiretroviral drugs do not have the same fear of HIV – most believing one can simply take a pill and be cured. Informants believe such attitudes reinforce the continuation of teens' risky behaviors.

Another recent trend is the use of phone apps to connect anonymously with others for the purpose of sexual activity. Many of the newly diagnosed MSMs have multiple contacts, all or many of whom may be unknown to them. A particularly disturbing side to this was the belief that some teens are intentionally targeted by older adult males. Some parts of the State have active social networks or "families" that engage in sex parties and orgies and are sworn to keep their identities from DIS workers making the job of surveillance even more difficult. These comments are presented below.

Focus Group Comments

- "One of the things we are seeing in the Delta is an increase in the young MSMs, as young as 17-24. What we're beginning to see is that they are dating on-line, going to websites, and those guys have been targets."
- "We're seeing an increase in young Black MSM."
- "Young Black men. There was a report out about a month ago where Jackson, Mississippi had the highest HIV population among young gay and bisexual men. Higher than the national rate."
- "It's getting younger and younger. It used to be you didn't see cases until about 18-19, recently it's been mid-teens and some of them as young as 15 but 17, 16 more of them diagnosed in that group."

- "I think we're seeing it in young Black MSMs."
- "We are missing a sex education component in the school system, young people are not educated about HIV or prevention."

Key Informant Comments

- "There's a misconception of what sex is. They [teens] believe that anal sex is not sex. Only when a penis penetrates a vagina is it sex, anything other than that is not sex."
- "Kids are using apps [Facebook, Grinder, etc.] . . . they're lying about their identity."
- "It's all anonymous . . . 'when we gonna meet, how long we gonna meet' – that's all we need to talk about."
- "They hook up and somebody gets HIV and they don't know who they were with; they use pre-paid phones."
- "In the Delta they have a group they call the Family and they all socialize together. It's kind of like a mafia – you get in; you don't talk about whatever is going on in the Family. They're going to protect each other."
- "I think that young people today, they didn't see people dropping like flies in the '80s – they didn't experience it, so in some ways they take it for granted. Even though they contracted this life-threatening disease, it's not registering that you're going to get sick if you don't go to care – because they feel fine now."
- "I go back to education. What we have now is abstinence or abstinence plus."
- "The information is out there about the medicine. That's one of the reasons now that people are so nonchalant about it because the young people see older people who have had it for 10 or 15 years just taking the medicine so they figure, 'OK, I'll just take my medicine,' and just go back and feel invincible."

Sexual Activity and Prevention

Approximately half of survey respondents report they engaged in sexual activity in the last year. Of those engaged in sexual activity, approximately half are using condoms or latex barriers on a regular basis. When asked why they are not using prophylaxis on a regular basis the usual responses are, "I love and trust my partner," or "I don't or my partner doesn't like using condoms". The majority of those using condoms avail themselves of free condoms. Data tables and details are presented below.

Consumer Survey

- Approximately 46% of survey respondents from Mississippi reported engaging in anal, vaginal or oral sex in the last year, compared to 53% of survey respondents from the Jackson MSA.

Table B.3
In the past 12 months have you had receptive anal, vaginal or oral sex?
Mississippi State and Jackson MSA Consumer Survey

Sexual Activity	Mississippi State Consumer Survey n=319		Jackson MSA Consumer Survey n=130	
	#	%	#	%
Yes	145	45.5%	69	53.1%
No	157	49.2%	57	43.8%
I don't remember	4	1.3%	1	0.8%
None of the above, I haven't had sex	13	4.1%	3	2.3%

- Over half of all Mississippi consumer respondents (55%) engaging in sexual activity report using prophylaxis when engaging in receptive sexual activity on a regular basis.
- Less than half (48%) of Jackson MSA consumer respondents report using prophylaxis on a regular basis when engaging in receptive sexual activity.

Table B.4
Of the times you had receptive sex, how many times did you use a condom or latex barrier?
Mississippi State and Jackson MSA Consumer Survey

Times prophylaxis used	Mississippi State Consumer Survey n=145		Jackson MSA Consumer Survey n=69	
	#	%	#	%
0	19	13.1%	8	11.6%
One	9	6.2%	8	11.6%
Two – Five	17	11.7%	11	15.9%
Six – Nine	21	14.5%	9	13.0%
Ten	79	54.5%	33	47.8%

- Reasons for not using protection on a regular basis are similar across the State and in the Jackson MSA.
  - Survey respondents from Mississippi who did not use protection on a regular basis report "I love and trust my partner" 56%, "My partner doesn't like using protection" 39%, "I don't like using protection" 39%, and "Protection interferes with sexual activity" 38%, as the top three reasons for not using protection.
  - Survey respondents from the Jackson MSA who did not use protection on a regular basis report, "I love and trust my partner" 56%, "My partner doesn't like using protection" 39%, and "Protection interferes with sexual activity 36%, as the top 3 reasons for not using protection.

Table B.5
Why don't you use protection all the time when having sex?
Mississippi State and Jackson MSA Consumer Survey

Reasons	Mississippi State Consumer Survey n=66		Jackson MSA Consumer Survey n=36	
	#	%	#	%
I love and trust my partner	37	56.1%	20	55.6%
My partner doesn't like using protection	26	39.4%	14	38.9%
I don't like using protection	26	39.4%	12	33.3%
Protection interferes with sexual activity	25	37.9%	13	36.1%
Protection is not always available	24	36.4%	7	19.4%
It's not really sex with protection	14	21.2%	6	16.7%
Sometimes I'm high or buzzed on drugs and alcohol during sex	14	21.2%	10	27.8%
I don't care about protection	13	19.7%	7	19.4%
I want to have a baby	13	19.7%	6	16.7%
Problem with erection (ED)	11	16.7%	5	13.9%
Just don't use them	1	1.5%	1	2.8%
I have a positive partner	1	1.5%	1	2.8%
I am married / Have one partner	1	1.5%	0	0.0%

- Eighty-nine percent of survey respondents from Mississippi who report using prophylaxis are accessing free condoms, compared to 86% in the Jackson MSA.
  - Twenty-three percent of survey respondents from Mississippi, compared to 28% from the Jackson MSA don't use prevention.
  - Half or close to half in Mississippi and Jackson MSA have attended safe sex workshops.

Table B.6
What types of prevention services do you use?
Mississippi State and Jackson MSA Consumer Survey

Use of Prevention	Mississippi State Consumer Survey n=66		Jackson MSA Consumer Survey n=36	
	#	%	#	%
Free Condoms	59	89.4%	31	86.1%
Syringe Exchange	0	0.0%	0	0.0%
HIV Hotlines for Information	12	18.2%	7	19.4%
Safer Sex Workshops	33	50.0%	16	44.4%
Behavioral Intervention Classes	20	30.3%	10	27.8%
I don't use Prevention Services	15	22.7%	16	27.8%

PrEP

Mississippi has made an active effort to promote the use of PrEP and has established the service within Family Planning Centers funded by Medicaid. Other sources of funding are available from pharmaceutical assistance programs. Twenty-six percent of survey respondents who reported sexual activity in the last year reported their partners were taking medicines to avoid HIV.

More widespread use of PrEP will likely be seen over time as information is disseminated throughout the State to both potential consumers and to providers. Moreover, information, education and acceptance, and a reliable source of payment for services, will be key factors in the success of efforts to engage providers and consumers in using ART to reduce the spread of HIV.

Comments from focus groups and key informant interviews demonstrates a widely different range of knowledge about payment options, as well as differences in the availability of PrEP by region. Differences in knowledge and acceptance of the use of PrEP are noted by the provider community and consumers.

Consumer Survey

A higher than anticipated number of survey respondents reported their partners were taking medicine to avoid HIV, especially given access barriers related by focus group participants and key informants.

- Twenty-six percent of survey respondents from Mississippi report their partner is taking medicine to avoid HIV.
- A slightly higher percentage of Jackson MSA survey respondents report their partner is taking medicine to avoid HIV (29%).

Table B.7
Has your partner taken medication to avoid HIV?
Mississippi State and Jackson MSA Consumer Survey

Partner takes medication to avoid HIV	Mississippi State Consumer Survey n=145		Jackson MSA Consumer Survey n=69	
	#	%	#	%
Yes	38	26.2%	20	29.0%
No	75	51.7%	25	36.2%
I don't know	32	22.1%	24	34.8%

Barriers to PrEP

Focus Group Comments

- We do a lot of PrEP, we have about 130 patients enrolled in the program. It's paid for through Medicaid and there are patient assistance programs for patients who can't afford it."
- "Information about PrEP is spread through word-of-mouth."
- "Patients don't want to take medications every day because if they do, someone might find out."

- "You can get PrEP through family planning but when they [consumers] go to get these services, they are normally denied."
- "When it comes to getting PrEP through the Health Department you're not going to get it. You have to go through a private source . . . There are limited services you are going to get through the Health Department. This is Mississippi."

Key Informant Comments

- "PrEP is new in my area [District 1]. I had to introduce it to my providers, they never heard about it . . . I have to introduce it to clients here."
- "Stigma is still a problem, education and lack of knowledge about PrEP and how to use it."
- "In this area [District 4] we don't offer it. I don't have anyone in my 10 counties . . . I don't have any doctor or facility that carries PrEP."
- "The general public is not aware of PrEP . . . I don't think the medical community is aware it exists."
- "There is a fear of side effects and the long term effects of it."
- "Providers are concerned about, "What is it going to cost my client?" – that's been a barrier . . . what happens with maintaining these clients over a long period of time with PrEP – who's going to pay for the tests, especially when they have to come in every three months; who is going to pay for the maintenance of the client?"
- "Until three months ago the LGBTQ clinic in Jackson was the only provider. Since then we've been trained and we recruited two physicians in the private sector to be PrEP providers."
- "There are very few access points for PrEP. There is widespread ignorance. There is no funding source, it's expensive and most doctors are ignorant of it."
- "PrEP is not widely used in Mississippi, except perhaps in the Jackson area and specifically among certain MSMs who are in college or college-educated. There isn't much awareness of PrEP, so it's not heavily used."
- "Until recently there was only one place in Mississippi where you were able to access PrEP."
- "I don't think the average general practitioner in Mississippi is aware of PrEP."
- "There is a lack of education about PrEP and the use of PrEP."
- "PrEP is available in one location in the State, and it's just limited, although there are good opportunities for PrEP, it has not been accepted by the broader provider community, so it really hasn't been implemented."
- "There's a negative stigma – if you're going to get PrEP it means you are engaging in risky behaviors and you don't' want to stop and you're with an HIV+ partner."

C. FINANCIAL AND HUMAN RESOURCES INVENTORY

JURISDICTIONAL HIV RESOURCES INVENTORY

The MSDH receives HIVAIDS funding from State of Mississippi and the following federal programs: CDC, RWHAP Part B and HOPWA. HRSA awards RWHAP Parts C, D, and F. contracts directly to Mississippi health care providers. HOPWA funding supports programs to alleviate homelessness. Medicaid supports one HIV test annually for those deemed in need of the test. In addition, the Memphis MSA has received Part A funds which in part support care of HIV/AIDS residents in the four northern Mississippi counties of Desoto, Tate, Tunica and Marshal and Vanderbilt University, Tennessee has awarded UMMC a sub-grant from their Part F grant for provision of AETC.

HRSA defines core medical services include outpatient and ambulatory health services, linkage to ADAP and, AIDS pharmaceutical assistance, oral health care, early intervention services, home health care, medical nutrition therapy, hospice services, home and community-based health services, mental health services, outpatient substance abuse care, and medical case management, including treatment-adherence services. Support services include outreach, medical transportation, linguistic services, respite care for caregivers of people with HIV/AIDS, referrals for health care and other support services, non-medical case management, and residential substance abuse treatment services.

Table C.1 shows the source of funds, amount received and the purpose of those funds.

Table C.1
2016 State Appropriations and Federal Grants / Cooperative Agreements for Mississippi

State Funds	**Amount Received**	**Budget Period**	**Action or results promised in order to receive funds**
MSDH HIV Prevention	$ 700,000	FY2016	State match funds are used to augment activities for HIV prevention and treatment.
Organization Earmarks	$ 60,000	FY2016	The funds must be used for 3 organizations cited in the bill.
RW Part B Match Requirement	$ 1,900,000	FY2016	The funds are used to support ADAP medications.
Federal Funds	**Amount Received**	**Budget Period**	**Action or results promised in order to receive funds**
Evaluation of STD Programs Deploying DIS to Improve HIV Outcomes	$ 190,000	FY2016	The purpose of this program is to evaluate STD program models that use DIS workforce to improve HIV outcomes, particularly those related to identification of new HIV cases, linkage and re-engagement in HIV care, and linkage and referral to HIV prevention services, including PrEP.
Improving STD Programs Thru Assessment, Assurance, Policy Development and Prevention Strategy (AAPPS)	$ 1,369,280	CY2016	The purpose of this program is to strengthen STD prevention by focusing on 1) Increased community screening and treatment per CDC guidance; 2) Improved services for STD clients and their partners including linkages to care; 3) Reduced re-infection; and 4) Increased community and provider knowledge of STD-related treatment, prevention, epidemiology and effective policies.
Viral Hepatitis Prevention and Surveillance	$ 111,389	FY2016	The purpose of the program is to support the goals of the HHS Viral Hepatitis Action Plan by focusing on 1) addressing national viral hepatitis prevention and 2) surveillance priorities for increasing testing and access to care and treatment and strengthening surveillance to detect viral hepatitis transmission and disease.

(Table continues)

Federal Funds	**Amount Received**	**Budget Period**	**Action or results promised in order to receive funds**
Ryan White CARE Act Title II Part B Formula Award	$ 15,754,126	FY2016	Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) provides grants through the Health Services and Resources Administration (HRSA) to improve the quality, availability, and organization of HIV health care and support services. Within the Mississippi Part B grant there is: a base grant for core continuum of care medical and support services; the AIDS Drug Assistance Program (ADAP) award; the Part B Supplemental award for recipients with demonstrated need; Minority AIDS Initiative funding for education and outreach to improve minority access to medication assistance programs, including ADAP; and supplemental grants to States with "emerging communities."
Ryan White Part B Supplemental Grant	$ 5,875,000	FY2016	For recipients with special needs.
Ryan White Part C grants	$ 3,033,805	FY2016	HRSA directly awards not for profits to provide Early Intervention Services (EIS) program grant funding to local community-based health organizations to support comprehensive primary health services in outpatient ambulatory health settings and support services.
Ryan White Part D grants	$ 484,082	FY2016	HRSA direct awards not for profit organizations to provide outpatient ambulatory family-centered primary and specialty medical care and support services for women, infants, children, and youth living with HIV.

(Table continues)

Federal Funds	**Amount Received**	**Budget Period**	**Action or results promised in order to receive funds**
Ryan White Part F grants	$ 252,382	FY2016	HRSA directly awards to a Community-Based Dental Partnership Program (CBDPP) to increase access to oral health care services for PLWH while providing education and clinical training for dental care providers, especially those practicing in community-based settings.
	$ 238,000	FY2016	Vanderbilt University, Tennessee awarded a sub-grant to UMMC to provide AIDS Education Training services to professionals.
CDC: HIV Medical Monitoring Project	$ 424,269	FY2016	MMP is a surveillance system designed to learn more about the experiences and needs of people who are living with HIV.
National HIV Surveillance System (NHSS)	$ 737,709	CY2016	The NHSS collects timely information used to track the HIV/AIDS epidemic for 3 categories of diagnoses collectively: (1) a diagnosis of HIV infection (not AIDS), (2) a diagnosis of HIV infection and a later diagnosis of AIDS, and (3) concurrent diagnoses of HIV infection and AIDS. HIV/AIDS surveillance data are collected using standard confidential case reports and are reported to CDC without personal identifiers.
Secretary's Minority AIDS Initiative Funding for Care and Prevention in the United States (CAPUS)	$ 55,000	FY2016 (4^{th} Yr. No-Cost Extension)	The CAPUS Demonstration Project is a 3-year demonstration project led by the CDC. The purpose of the project is to reduce HIV and AIDS-related morbidity and mortality among racial and ethnic minorities living in Mississippi. The goals of the project are to increase the proportion of racial and ethnic minorities with HIV who have diagnosed infection by expanding and improving HIV testing capacity, and to optimize linkage to, retention in, and re-engagement with care and prevention services for newly diagnosed and previously diagnosed racial and ethnic minorities with HIV.

(Table continues)

Federal Funds	**Amount Received**	**Budget Period**	**Action or results promised in order to receive funds**
Comprehensive HIV Prevention Projects for Health Departments Categories A and B	$ 3,030,531	CY2016	HIV Prevention Category A is used to implement a High-Impact Prevention approach to reducing new HIV infections, using combinations of evidence based, cost-effective, and scalable interventions targeted to appropriate populations in the right geographic areas, to increase the impact of HIV prevention efforts and achieve the goals of the National HIV AIDS Strategy. HIV Prevention Category B is used to expand HIV testing in healthcare settings as a scalable intervention targeted to reach the at-risk populations in the targeted geographic areas, to increase the impact of HIV prevention efforts and achieve the goals of the National HIV AIDS Strategy.
HOPWA	$ 2,456,198		Funds provide services for low-income persons/families with HIV/AIDS to prevent homelessness. Eligible activities are Short-Term Rent, Mortgage and Utility assistance (STRMU), and Tenant-Based Rental Assistance (TBRA).
TOTAL	$ 36,671,771		

The amount and percentage of funding available to support State of Mississippi HIV/AIDS prevention, care and treatment and housing support programs in FY2016 is $36,671,771 and comes from the following sources as found in Table C.2.

Table C.2
Funding Availability

Funder	Purpose	Amount	Percent
Ryan White Parts B, C, D, F	Care and Treatment, AETC	$25,637,395	69.9%
CDC	Prevention, MMP and Surveillance	$ 5,918,178	16.1%
HOPWA	Housing Support	$ 2,456,198	6.7%
State of Mississippi	Prevention, Earmarks, Part B match	$ 2,660,000	7.3%
TOTAL		$36,671,771	100%

This Table shows that the greatest source of the State of Mississippi's HIV/AIDS funding is the Ryan White HIV/AIDS Program.

The state is awarded the RW Part B funds and sub grants to health organizations, pays for home health Care and the ADAP program. Ryan White Parts C, D and F funding is awarded through an RFP process directly by HRSA. HOPWA funding is awarded to the state which distributes the funds to the City of Jackson and the Mississippi Home Corp, a government agency. CDC funding is distributed through a formula grant to the MSDH for HIV surveillance and prevention and sub grants to community organizations. The interaction of the different funding sources varies from health district to health district and is dependent on the sources of funding which flow into each health district. The funding received by the state and not distributed to organizations is primarily used to pay for health department staff deployed to the health districts, STD and HIV medication, purchases and operational activities.

Grant recipients are required to spend at least 75% of their Part B grant funds on core medical services and no more than 25% on support services. All recipients and sub-recipients must vigorously pursue enrollment in available health coverage options for eligible clients.

Twelve health care organizations are sub-grantees of Part B funds. Six health care organizations receive Part C funds, one health care organization receives Part D funds and one health organization receives Part F funds directly from HRSA and a Part F sub-award from another grantee, the Southeast AETC at Vanderbilt University in Tennessee. All but two of the nine health districts, Districts 4 and 6, are recipients of RWHAP funds.

<u>Public Health District 1</u>

Memphis Part A: Desoto, Tate, Tunica Counties

Part B: **The Deporres Health Center**, located in Marks, is a primary care clinic staffed with an infectious disease physician which provides HIV/AIDS testing and treatment, medical case management, outpatient ambulatory services and transportation services. It is one of two health centers in Public Health District 1 receiving RWHAP funds; the other center receives Part C funds.

Part C: The **Aaron E. Henry Community Health Services Center** (AEH), a Federally Qualified Health Center located in Clarksdale, serves five rural counties through three freestanding clinics, two school-based clinics and two mobile clinics. Services at AEH include outreach, education, counseling, testing, diagnosis, treatment, prophylaxis, oral health and management of opportunistic infections. AEH also provides a cadre of enabling services to include public transportation, WIC and nutrition, social services, outreach and access to pharmaceuticals. A full array of HIV primary services is provided, including continuity care of chronic HIV, Hepatitis B and C treatment, as well as all necessary ancillary support services including mental health, woman's health, vision, and other subspecialty referral services. Aaron E. Henry provides a Medical Home for the estimated 70 PLWH who currently lack access to appropriate health care services due to the relinquishment of the Ryan White Part C grant by the Tutwiler Clinic.

Public Health District 2

Memphis Part A - Marshall County

Part B: **North Mississippi Medical Center, Garfield Clinic,** located in Garfield, provides outpatient ambulatory and transportation services and is the sole RYHAP provider in Public Health District 2.

State: **North Mississippi Medical Center, Garfield Clinic** provides medications and transportation.

CDC**: University of Mississippi** provides prevention.

Public Health District 3:

Part B: **Greenwood Leflore Hospital's Magnolia Medical Clinic**, located in Greenwood, provides outpatient ambulatory services, oral health and mental health services. It is one of two Part B funded programs in Public Health District 3 and also receives a Part C grant. **Crossroads Clinic North (Delta Regional Partnership),** located in Greenville, provides Early Intervention Services for PLWHS, most of whom are low-income African Americans.

Part C: **Delta Regional Medical Center,** located in Greenville, provides Early Intervention Services for PLWH, most of whom are low-income African Americans. The Medical Center also has received a Part B sub grant.

State: **Southern Health Commission,** located in Greenville**,** receives a sub grant to provide prevention and education services.

CDC: **Southern Health Commission** provides prevention services.

Public Health District 5

Part B: **The University of Mississippi Medical Center** (UMMC) receives four sub grants to support HIV clinics in the ***Division of Infectious Diseases*** and the ***Department of Pediatrics*** providing outpatient ambulatory services to adults and children respectively. The Adult ***Special Care Clinic*** and its ***Dental Clinic*** provides oral health services. **MSDH's Crossroads Clinic Central** serves the metropolitan Jackson area. **Hinds County Mental Health Commission**, located in Jackson, provides mental health services. **My Brother's Keeper - Open Arms Health Center,** located in Jackson, focuses on the healthcare of the LGBTQ community and provides outpatient ambulatory services, mental health and transportation services to MSMs and other PLWH.

Part C: **The University of Mississippi Medical Center** (UMMC) ***Adult Infectious Disease Clinic,*** known as the ASCC and located at the Jackson Medical Mall, provides services contributing to the Continuum of Care for HIV-infected individuals including medical evaluation and clinical care, referral to the dental clinic and to multiple specialty and subspecialty clinics available within the Jackson Medical Mall as part of UMMC. These clinics are cardiology, endocrine, gastroenterology, gynecology, hematology, orthopedics, ophthalmology, oncology, pain management, surgery, urology, and renal services. The majority of new ASCC clients are referred from Crossroads Clinic Central located in Jackson, which has the largest proportion of population that undergoes HIV testing in the state. Other infected PLWH, mostly

African Americans, are direct referrals from the state prison system, with the assistance of their clinic case management team. Other clients are referred from UMMC Ryan White Part D program. The **G.A. Carmichael Family Health Center**, (GACFHC) located in Canton, serves predominately rural counties in central and northern Mississippi, a medically underserved area. The clinic service area encompasses eleven counties of Mississippi's Public Health Districts 3, 5, and 6. These counties are Attala, Carroll, Holmes, Humphreys, Leflore and Montgomery in District 3; Madison, Yazoo, Sharkey and Issaquena, District 5; and Leake County in District 6. The Center provides comprehensive primary care including early intervention services in an outpatient setting utilizing a multi-disciplinary model including HIV counseling and testing, primary care, and coordination and referrals to other health and support services. GACFHC services provided are primary comprehensive medical care, oral health care, adherence education, social services, access to outpatient mental health services, substance abuse screening, nutritional screening, outreach, education, counseling, testing, diagnosis, treatment, prophylaxis, management of opportunistic infections, risk reduction counseling, and referral services. Routine immunizations, perinatal HIV testing, patient assistance programs, patient education and case management services are also being provided.

Part D: The **University of Mississippi Medical Center** (UMMC) ***Pediatric Infectious Disease Division,*** located in Jackson, is the only perinatal HIV care site in the state. It serves all pregnant women, infants and children throughout the State living as PLWH and adolescents from the greater Jackson metropolitan area, a population that is mostly African American.

Part F: **The University of Mississippi Medical Center (UMMC)** ***School of Dentistry Oral Maxillofacial Surgery Department***, located in Jackson and serving clients throughout the State, has received a Community-based Dental Partnership grant for the provision of oral maxillofacial surgery. Patients of the Jackson Medical Mall Dental Clinic are referred to the OMS department for needed services including extraction of complex teeth and biopsies. **The University of Mississippi Medical Center (UMMC)** ***Department of Infectious Diseases*** receives Southeast AIDS Education and Training Center (AETC) support from the Part F grantee in Tennessee (Vanderbilt University).

State: **Grace House**, located in Jackson, receives funds to provide prevention and education activities.

CDC: **Jackson State University, Jackson Hinds Comp. Health Center, and My Brother's Keeper** provide prevention services. **UMMC** provides STD services, **Jackson Medical Mall Foundation Care 4 Me Program, The Jackson Advocate, Central MS Residential Center and Grace House provide prevention services; MS Public Health Institute provides Evaluation services.**

<u>Public Health District 7</u>:

Part B: MDOH's **Crossroads Clinic South,** located in McComb provides Early Intervention Services.

State: **Alcorn State University** provides HIV prevention services.

<u>Public Health District 8</u>

Part B: **Southeast Mississippi Rural Health Initiative, Inc.** (SeMRHI), located in Hattiesburg provides Early Intervention Services and also receives a Part C grant directly from HRSA.

Part C: **Southeast Mississippi Rural Health Initiative, Inc.** (SeMRHI) provides Early Intervention Services as well an medical and dental services for PLWH in a 16 county area It also receives a Part B sub grant. Its patients are predominately African America male.

State: **AIDS Service Coalition**, located in Hattiesburg, receives funds to provide prevention and education activities. **University of Southern Mississippi** provides prevention services.

CDC: **Southeast Mississippi Rural Health** provides prevention services.

Public Health District 9

Part C: **Coastal Family Health Center,** located in Biloxi, provides HIV Early Intervention Services which include medical, dental, optical, laboratory, case management and counseling for PLWH and outreach services for those at risk. Its service areas are Harrison, Hancock and Jackson counties with participating clinics in Bay St. Louis, Biloxi, and Gulfport (dental services) Mississippi.

CDC: **Coastal Family Health Center** and **My Brother's Keeper LGBT Wellness Program** provide prevention services.

Statewide:

Part B: MDOH's **Public Health Lab** receives funds to support testing and outpatient ambulatory services. **MAI** funding supports three nurses at the three state prisons who provide HIV/AIDS prevention, education and linkage/referral to inmates scheduled for discharge. **ADAP** funds pay for medications not reimbursed by a third party insurer for eligible PWLAs to receive life-saving HIV antiretroviral medications. Prescriptions are filled by a centralized pharmacy. **MDOH** Case Managers are assigned to each public health district. Public Health District 5 presently has two HIV case managers, one of which is the supervisor. The HIV case managers are social workers who assist clients with service such as linkages to health services and obtaining support such as housing, food, support groups and retention in care.

CDC: MDOH's **Public Health Lab** receives funds to support chlamydia, gonorrhea, syphilis and HIV testing staff and services. The **American Sexual Health Association (ASHA**) receives funds to provide PrEP social media content. **Contact the Crisis Line** is funded to provide a toll free HIV Crisis Hotline.

HOPWA funds provide services for low-income persons/families with HIV/AIDS to prevent homelessness. Eligible activities are Short-Term Rent, Mortgage and Utility assistance (STRMU), Tenant-Based Rental Assistance (TBRA). The **City of Jackson** and the **Mississippi Home Corp.** have received sub grants to provide these services. These agencies receive referrals from all the funded programs.

The majority of care and treatment services receiving Ryan White Funds, Parts B, C D and F are provided in PHD 5, City of Jackson in Hinds County. Most of the funded care and treatment services are located in clinics of the University of Mississippi Medical Center, My Brothers' Keeper's Open Arms Health Care Clinic, and the MSDH Crossroads Clinic. PHD 3 provides services at 3 clinics. Each Public Health District has an HIV/AIDS case manager to provide information and linkages to care. CDC HIV Prevention funding is sub-granted to several community based organizations, FQHC clinics, HBCUs, and supports HIV testing

at several DOMH substance abuse centers. Federal HOPWA funding is sub-contracted to two Project Sponsor agencies, both community-based organizations.

Funded programs refer clients to each other depending on the needs of the clients and the availability of resources outside of a public health district to meet special needs of PLWHs.

Medical and non-Medical case managers provide linkage to other services.

Private foundations ViiV Healthcare, Elton John AIDS Foundation, and the Elizabeth Taylor AIDS foundation has provided funding to community based organizations throughout the state.

NEEDED RESOURCES/SERVICES IN THE JURISDICTION NOT BEING PROVIDED

The number of new cases each year does not appear to be less than the previous years, more PLWH are living and thus the caseload for care and treatment and support services is increasing and more members of the community need to be reached with HIV/AIDS prevention and education. Needed resources:

- Funded HIV/AIDS services are not available in Public Health Districts 4 and 6. Residents must travel to another area to access any services.
- The cost of travel to initially obtain services may be beyond the individual's budget. After one becomes a client/patient then Medicaid authorization for travel can be requested and a transportation voucher issued for an appointment. Transportation vouchers need to be available for those initially seeking an appointment
- Sufficient funding is needed to support the infrastructure of the MSDH to attract qualified candidates for open positions and retain experienced personnel.
- Few CBOs that intersect with the targeted populations are funded.
- Prisoners scheduled for discharge from the State Prisons receive HIV education and prevention services, yet the care and treatment of infected prisoners appears to not require funding.
- Support groups do not appear to be funded.
- Free, routine testing of the general population is not provided. In accordance with Mississippi Medicaid rules testing is limited to only those for whom it is deemed necessary.
- An online directory of HIV/AIDS services in Mississippi could be more user friendly by describing the services each organization provides for at-risk and those infected/affected by HIV/AIDS and arranged by public health district or location.
- There appears to be a program evaluation mechanism in place by each funder. However, the results of the evaluations are not public.
- MSM is a major cohort of those infected with HIV/AIDS. Not all at risk or infected feel safe identifying as LBGTQ. LBGTQ health care appears to receive attention in only one funded program.
- We cannot speak to the adequacy of the number of care and treatment personnel on board as we do not know how long it takes for someone to receive services…. are there waiting lists and if so why?
- The HIV Continuum of Care model focuses on services for individuals who present as possibly infected with HIV/AIDS. Testing and prevention activities take place during visits. CDC funded Education and Prevention activities targeted to the community do not appear to be woven into the Continuum of Care model. Are there the linkages amongst Community Education and

Prevention activities and organizations funded for the care and treatment of those infected and affected by HIV/AIDS.

HIV WORKFORCE CAPACITY

- The HIV workforce capacity depends on the interest and availability of professional and non-credentialed individuals, their interest in working in Mississippi, compensation offered, education, training and experience for open positions.
- The State of Mississippi is designated as a Health Professionals Shortage Area (HPSA) in the areas of primary care, dental care and mental health. The number of unfilled positions in these disciplines is difficult to assess. Mississippi has the lowest primary provider workforce in the nation, about 109 active physicians per 100,000 people, compared to the national average of about 261 active physicians per 100,000 people. Health Districts 4 and 6 have limited physician availability as they do not stay in the area very long and they do not have HIV specialty experience. Thus medical care is not available to HIV/AIDS patients within those two districts. A search of HRSA's National Health Services Corp (NHSC) job site indicates that as of August 14, 2016 there were 7 open positions for dentists, 18 open positions for mental health professionals and 16 open positions for primary care doctors, 1 OB/GYN and 6 nurse practitioners. None of these primary care positions were located in presently funded HIV programs. That could be due to open positions within funded programs not being listed on that database.
- The amount of funding available to support the existing HIV/AIDS workforce is very stretched to pay the salaries of the HIV/AIDS health care providers. MSDH is aware that one or more of its funded programs may not be able to continue to provide services due to limited funding. In the event funding awards were increased to pay for hiring additional HIV/AIDS experienced staff, the challenge would be finding the appropriate candidates to fill additional positions in the clinics
- Data available and represented in Table C.3 indicates that all but 2 funded positions are filled. Manpower employed by HOPWA is not available. Available positions could be posted in the National Health Services Corp listing of open positions. Reduction of State funding and recent hiring guidelines to fill vacant state positions at the entry level have resulted in HIV/AIDS positions at MSDH not being filled such as the Case Management Supervisor position which requires a Licensed Social Worker.

Table C.3
Funded Workforce Capacity

	Licensed		Certification		Para Professional		Vacant		Volunteers	
Funder	**#**	**FTE**	**#**	**FTE**	**#**	**FTE**	**#**	**FTE**	**#**	**FTE**
Part B	37.5	27.2	6	3.32	4	3.4	1	0.5	0	
Part C	23	16.05	7	3.32	8	7.04	1	0.5	0	
Part D	10	4.05	0	0	0	0	0	0	0	
Part F	1	.50					1	1	8	3
CDC	2	1.3	3	3	31	20.03	0	0	0	
Total	**76.5**	**49.1**	**16**	**9.64**	**43**	**30.47**	**3**	**2**	**8**	**3**

HOW DIFFERENT FUNDING SOURCES INTERACT TO ENSURE CONTINUITY OF HIV PREVENTION, CARE AND TREATMENT SERVICES

- Sources of HIV/AIDS Care and Treatment Services extend beyond receipt of Ryan White HIV/AIDS Program funding. Third party reimbursement sources, such as Medicare, Medicaid and private insurance, are used as the first source of payment of primary care services.
- The RWHAP funding provides for delivery of a range of services that are not billable to third party insurers.
- In Mississippi, the high rate of unemployment, Medicaid eligibility, and the lack of resources to purchase health insurance severely impact the availability of funds to pay for the full range of services needed to prevent, educate, care and treat as well as provide the range of support services that will enhance the health and well-being of PLWHS.
- Other State of Mississippi Departments and community organizations receive federal funds from SAMSHA for drug prevention and mental health treatment and from HHS for Community Mental Health Clinics.
- A more complete picture of the funding sources, including the value of third party reimbursements and private funding is not encompassed within this report.
- The MSDH leverages resources through partnerships with the Memphis MSA Program Part A, several Part C clinics, privately funded clinics, other Mississippi state health programs such as the Tuberculosis Program and 87 district health clinics as of July 2016.

STEPS TAKEN TO SECURE NEEDED RESOURCES

- Existing funded providers request grants from HRSA, CDC, HOPWA and the State of Mississippi legislature.
- The MSDH's request of an increase in the State's financial commitment can be supported by an educated community becoming engaged in grass roots advocacy for sufficient funding. The funding could then be used to hire MSDH staff to manage and supervise the State's HIV/AIDS plan and to provide funding to local community based organizations that intersect with the target populations.
- Interagency collaboration by the MSDH with the Department of Corrections prison system and Medicaid continues in order to increase the range of services available to prisoners and the general population.
- To better support the integration of HIV prevention and care service delivery, CDC and HRSA have developed guidance with a new format to support the submission of an Integrated HIV Prevention and Care Plan, including HIV prevention and care planning activities for jurisdictions, as well as the Statewide Coordinated Statement of Need beginning in 2017. Integrated planning will identify gaps in resources, streamline the deployment of resources and provide a case statement for the need of additional resources.

D. ASSESSING NEEDS, GAPS AND BARRIERS

PROCESSES USED

Mississippi State Health Department staff identified a list of 26 individuals with direct knowledge and experience in working with PLWH and those at high risk for infection. The list included direct care providers (physicians, dentists, nurses, and mental health professionals), LGBTQ advocates, program directors, AIDS service organizations, community-based organizations, community leaders, and University of Mississippi Medical Center staff.

From this list, 10 interviews were conducted with individuals from throughout the State who represented a wide variety of HIV service organizations, disciplines and advocates. These interviews were conducted in May 2016. All interviewees were asked and agreed to participate in the study.

Three sets of focus groups were conducted between June 15 and 17. MSDH assisted in recruitment of focus group participants. Group 1 included Ryan White medical providers. Group 2 included Mississippi HIV Planning Council leadership and members, including PLWH. Group 3 included Ryan White-funded case managers, social workers and Disease Intervention Specialists, and HOPWA providers.

Consumer survey respondents were recruited at 14 provider sites throughout the State. Each site made computers available to consumers so that they could complete the on-line survey at the office. ADAP staff made calls to consumers asking them to participate in the survey and assisted consumers by completing the survey over the telephone. ADAP staff also asked clients who called into the office if they would be willing to participate in the survey. Flyers, including log-in information, were made available to clients at testing centers and other provider sites, so that they could complete the on-line survey at their convenience using a computer, smart phone or tablet. Unfortunately, one site in District 5 reported after the survey was completed that several clients erroneously took the survey twice.

It should be noted that 22 of the consumers who completed the survey were out-of-care having met either the HRSA or expanded out-of-care definition (see page 6). In an attempt to ensure additional representation of out-of-care consumers, staff from the Medical Monitoring Program (MMP) sent letters to out-of-care consumers asking them to participate in an interview but this method yielded few respondents. A survey undertaken in December 2015 by MMP was shared with consultants to provide additional input from out-of-care PLWH.

HIV PREVENTION AND CARE SERVICES NEEDS OF PERSONS AT RISK FOR HIV AND PLWH

Prevention

Mississippi ranks 51st in terms of its economy, has the second highest poverty rate in the country, and ranks 43rd in terms of the percentage of uninsured residents, and 50th in terms of educational attainment. The socioeconomic factors at work in the State have a significant impact on the health and well-being of its residents. Mississippi currently ranks 49th in terms of the overall health of its residents. Residents of the State suffer from high rates of diabetes, obesity, smoking, heart disease, cancers and premature deaths, including premature deaths due to HIV.

Poverty impacts PLWH in disproportionate ways in terms of access to care and services. While testing services are widely available through the State, these activities are primarily funded by the CDC as little State funding is available. The lack of prevention funding for HIV is a dominant theme in the focus groups and among key informants. Furthermore, State requirements regarding abstinence education are viewed as impediments to restraining the increase in infections among youth. To improve prevention and education services among young people, funding was provided to four universities to support these activities.

Stigma, enhanced by HIV-specific state laws and confidentiality concerns have a highly negative impact on HIV prevention, testing and service utilization by PLWH and those at risk for the infection. These laws add to a perception of the Health Department as the "sex police". Religious/cultural issues also influence the stigma experienced by Black men which is strongly tied to religious beliefs and sexual identity.

Cultural attitudes about sex and lack of openness to discussing this subject adds to a public perception that HIV is not a serious public health issue which does not correlate to the extent of the problem in Mississippi or to the fact that the rate of infection in the State is rising at a time when treatment and prevention efforts are much improved. It does, however, contribute to a lack of serious concern about the disease as a public health issue.

In addition to inadequate education in schools, health literacy levels among the general population appear to be low. As one community provider observed, "If I don't think the message pertains to me, I'm probably not listening." The continued perception that HIV is a "gay men's" disease and attitudes of avoiding conversations about sex lead to a persistent lack of information about HIV. A lack of health prevention messages also leads to the belief that HIV is no longer problem; beliefs that are not borne out by the increasing infection rates. Community participants' comments regarding HIV prevention needs and concerns are presented below.

Focus Group Comments

- "I really see a void in the perception of how to deliver prevention, because if people don't know this disease can impact them they are not going to pay attention. We need to have a stronger component in outreach to bring awareness."
- "Stigma is the real big issue with HIV – no one wants to talk about it."
- "Educating the public about HIV is not being done as it should be, people are not getting that information."
- "If they don't come in for testing there is no way of communicating with them."
- The Health Department has done some campaigns but people just don't go for testing."
- "We have mass poverty; there is not much funding for education and there are high risk factors related to every category of health."
- "We don't have sex education."
- "Accepting the information is the problem – so having the right messenger and the right message is key to reaching people and making sure they hear what is being said."
- "We used to have an HIV Community Planning Group for prevention. That has been folded into the Ryan White Council, and eventually that prevention element has disappeared."

Key Informant Comments

- "For us to have prevention we have to acknowledge we have a problem, and that's the thing with the public officials. They don't want to admit there is a problem because Mississippi men aren't supposed to sleep with men."
- "Prevention is as good as your resources and my resources are limited."
- "We are the only clinic in the area doing prevention. We go out to the schools and talk about HIV. We bring an HIV+ person and let them tell the students their story."
- "News reports that begin with HIV is no longer a death sentence or play down the threat of HIV – I think it's sending out mixed messages that people are interpreting in a very detrimental way."
- "I see it as a missed opportunity because the prevention message is not as pronounced as it should be. I understand we live in the Bible Belt, but at the same time . . . just awareness . . . information to let people know the number of new HIV cases in their communities, more outreach. I know treatment is prevention, but at the same time, if we don't have prevention, then treatment always becomes prevention . . . We have to be on the front end as well."
- "In this region [District 3] we need to improve upon the education and prevention component to better retain clients."
- "Each organization needs to look at their community and how their community receives information in order to improve upon it."
- "Getting out into the community, schools, health fairs – I don't know that there is a lot of that going on."
- "There are not a lot of social barriers to prevention messages or even to putting up flyers. It's that those who need it mostly shy away from it . . . going into bars and mobile outreach doesn't work here . . . People come to Jackson for fun not to hear about HIV."
- "Diagnosing people is a challenge because of a lack of prevention and outreach."
- "We do a lot of testing here. I am not sure we are testing the right people; I think that's an issue."
- "The focal point of prevention in Mississippi has been on PrEP – really trying to ramp up efforts by getting more people enrolled, educated and informed about it."
- "Our efforts at prevention are focused on counseling our clients, so prevention takes the form of treatment."
- "I think the money that comes into the State for education needs to be in the communities, not necessarily in the Health Department."
- "In addition to testing, the Health Department is the main source and initiator of prevention messages through local health department clinics or media."
- "Condoms are available but they're not well linked to the communities' at risk."
- "People want to hear about it, but they don't want to get involved in the sense that they want to pretend this isn't happening in their community – it's in the city, not here (rural areas).
- "Sex is not openly discussed in the deep south – society is not comfortable with it."
- "Prevention is well done in Jackson. If you live in a rural area, you just learn that you have to go to an urban center for any kind of prevention services, testing – any of those things."
- "Urban centers have prevention services, but it's harder in rural areas."
- "About HIV in general, I think there's a 'What, that's still a thing?' with the general population. So, I think there's a need for real information about what's happening with HIV."
- "The public has a range of opinions and mindsets around prevention, if you were to sum it up, I would say it's conflicted."

- "Testing is widely available through the Health Department, how much the general population and those at risk access it is another matter. They try to promote their message through media that urge people to get tested but the statistics in Mississippi indicate there are likely quite a lot of undiagnosed patients in the State – so more testing needs to be done."
- "The people who test negative who are at high risk are not getting any additional tools to prevent transmission and there is even a belief that a negative test reinforces that their current behavior is just fine."

Service Needs

Mississippi residents have the lowest median household income in the U.S. at $39,464. Poverty rates in Mississippi are the second highest in the country and Mississippi ranks 43rd in terms of the percentage of uninsured residents. PLWH and those at risk tend to suffer from the same socioeconomic conditions, but to a greater extent than the general population. The following serves to demonstrate this conclusion. The uninsured rate in Mississippi is currently at 24.3%, while 68% of survey respondents report being uninsured. The majority (54%) of survey respondents report incomes below $24,000.

Economics, therefore, plays a significant role in the service needs of PLWH and those at risk. It is, therefore, not surprising that economic issues impact how PLWH ranked services they need but are not getting.

Consumer Survey

As noted below, beyond the issues of assistance with medical and dental services those issues that were most needed were help with housing, food and utilities. These same issues were of concern to consumers living in the Jackson MSA, as noted in Table D.2 below.

- Helping paying for insurance, co-pays and deductibles (27.8%)
- Dental care (24.1%)
- Help paying the mortgage (24.1%)
- Emergency financial assistance for utilities, food, medications (22.7%)
- Help paying for housing in an emergency (21.1%)

A full list of the service needs of Mississippians is provided in Table D.1 below.

Table D.1
Services Needed
Mississippi State Consumer Survey (n=319)

	I Don't Need It	I Get It	I Need It, But Don't Know How To Get It	I Don't Get It, But Need It
Services	**%**	**%**	**%**	**%**
Paying for HIV medications	14.7%	74.6%	4.7%	6.9%
Dental Care	14.4%	53.8%	7.7%	24.1%
Help Getting Other Medical Care	30.1%	47.2%	5.7%	17.1%

	I Don't Need It	I Get It	I Need It, But Don't Know How To Get It	I Don't Get It, But Need It
Services	**%**	**%**	**%**	**%**
Help Paying for Insurance, co-pays, deductibles	36.8%	28.4%	7.0%	27.8%
Health Care Services at Home	71.2%	16.1%	3.7%	9.0%
Mental Health Services	63.9%	19.1%	3.7%	13.4%
Nutritional Counseling	60.2%	23.4%	5.0%	11.4%
Food Bank	57.5%	18.1%	7.7%	16.7%
Meals Delivered to Home	79.3%	6.4%	5.4%	9.0%
Outpatient Substance Abuse Treatment / Detox	84.9%	5.7%	3.3%	6.0%
Residential Substance Abuse Treatment	87.6%	5.4%	2.7%	4.3%
Emergency Housing Shelter	79.3%	8.4%	3.0%	8.7%
Education to Help You Follow Your HIV Treatment	52.5%	34.8%	3.3%	9.4%
Case Management	29.1%	61.5%	2.7%	6.7%
Child Care Services	89.6%	3.3%	3.0%	4.0%
Emergency Financial Assistance for Utilities / Food / Medications	49.5%	18.7%	9.0%	22.7%
Help Paying the Mortgage	54.2%	12.7%	9.0%	24.1%
Help Paying for Housing in an Emergency	62.2%	8.7%	8.0%	21.1%
Education About HIV and How to Reduce Risks	55.5%	30.8%	4.7%	9.0%
Legal Services	75.6%	9.7%	3.7%	11.0%
Translation Services	86.3%	6.4%	2.0%	5.4%
Transportation to Medical Care	63.2%	23.1%	4.3%	9.4%
Transportation to Substance Abuse Treatment	86.3%	6.4%	2.7%	4.7%
Rehabilitation Services (PT, OT, Speech)	87.0%	5.7%	2.3%	5.0%
Medical Day Care	88.6%	4.0%	2.0%	5.4%

Jackson MSA residents ranked their needs in the following order:

- Paying for insurance, co-pays, deductibles (30.0%)
- Help paying the mortgage (24.6%)
- Dental care (20.8%)
- Emergency financial assistance for utilities, food, medication (20.8%)
- Help paying for housing in an emergency (20.0%)

A full list of the service needs of PLWH in the Jackson MSA is provided in Table D.2.

Table D.2
Services Needed
Jackson MSA Consumer Survey (n=130)

	I Don't Need It	I Get It	I Need It, But Don't Know How To Get It	I Don't Get It, But Need It
Services	**%**	**%**	**%**	**%**
Paying for HIV medications	15.4%	71.5%	6.9%	6.2%
Dental Care	12.3%	58.5%	8.5%	20.8%
Help Getting Other Medical Care	33.0%	43.8%	6.9%	15.4%
Help Paying for Insurance, co-pays, deductibles	35.4%	28.5%	6.2%	30.0%
Health Care Services at Home	64.6%	18.5%	5.4%	11.5%
Mental Health Services	66.2%	18.5%	5.4%	10.0%
Nutritional Counseling	59.2%	23.8%	5.4%	11.5%
Food Bank	54.6%	18.5%	8.5%	18.5%
Meals Delivered to Home	76.9%	10.8%	4.6%	7.7%
Outpatient Substance Abuse Treatment / Detox	76.9%	9.2%	7.7%	6.2%
Residential Substance Abuse Treatment	80.8%	9.2%	5.4%	4.6%
Emergency Housing Shelter	73.8%	13.8%	3.1%	9.2%
Education to Help You Follow Your HIV Treatment	56.2%	30.8%	5.4%	7.7%
Case Management	34.6%	55.4%	2.3%	7.7%
Child Care Services	83.1%	6.9%	4.6%	5.4%
Emergency Financial Assistance for Utilities / Food / Medications	56.9%	16.9%	5.4%	20.8%
Help Paying the Mortgage	54.6%	14.6%	6.2%	24.6%
Help Paying for Housing in an Emergency	66.2%	10.0%	3.8%	20.0%
Education About HIV and How to Reduce Risks	56.2%	27.7%	6.9%	9.2%
Legal Services	72.3%	13.1%	3.1%	11.5%
Translation Services	84.6%	7.7%	2.3%	5.4%
Transportation to Medical Care	60.8%	26.2%	3.1%	10.0%
Transportation to Substance Abuse Treatment	79.2%	10.0%	4.6%	6.2%
Rehabilitation Services (PT, OT, Speech)	80.0%	10.0%	3.8%	6.2%
Medical Day Care	83.8%	5.4%	3.8%	6.9%

Out of Care Interviews

Out of care consumers reported dental care and getting medicine through ADAP as their top needs.

Housing

- More than 25% of Mississippi survey respondents were living in subsidized housing, group homes, shelters, or on the street; and 30% were staying with family or friends.
- Nearly 40% of Jackson MSA survey respondents live in subsidized housing, group homes, shelters, or on the street; and more than 25% are living with family or friends.

Table D.3
Housing Situation
Mississippi State and Jackson MSA Consumer Survey

Housing Situation	Mississippi State Consumer Survey n=319		Jackson MSA Consumer Survey n=130	
	#	%	#	%
Staying with Family or Friends	94	29.5%	34	26.2%
Transitional Housing	0	0.0%	0	0.0%
Rent or Own House / Apartment / Condo (non-subsidized)	141	44.2%	46	35.4%
Rent or Own House / Apartment/ Condo (subsidized)	39	12.2%	14	10.8%
Live in Group or Congregate Housing with PLWH	21	6.6%	16	12.3%
"I am on the Street, No Home"	4	1.3%	3	2.3%
Adult Foster Home or Hospice	1	0.3%	0	0.0%
Temporary Housing / Treatment Facility or Halfway House	10	3.1%	9	6.9%
Shelter	9	2.8%	8	6.2%

- Ten percent of Mississippi survey respondents received HOPWA in the last 12 months, compared to 21% who say they need help with emergency assistance to pay for housing costs or to provide shelter.
- Approximately 17% of Jackson MSA survey respondents were receiving HOPWA, compared to 20% who need assistance.

Table D.4
Did you get HOPWA in last 12 months?
Mississippi State and Jackson MSA Consumer Survey

HOPWA	Mississippi State Consumer Survey n=319		Jackson MSA Consumer Survey n=130	
	#	%	#	%
Yes	33	10.3%	22	16.9%
No	253	79.3%	96	73.8%
Don't know / Don't remember	33	10.3%	12	9.2%

SERVICE GAPS

Overall, there is a severe shortage of physicians in the State of Mississippi. County Health Rankings data for 2016 puts the number of primary care physicians to population in Mississippi at 1,860:1 compared to 1,040:1 in the top U.S. performing areas.[16] The Health Resources Service Administration (HRSA) has given Mississippi 139 health professional shortage areas (HPSA) designations. Seventy-five of which are single county designations. Licensed physicians in Mississippi (medical doctors, osteopaths and podiatrists) in 2014 totaled 6,042 physicians, 41% of which are primary care physicians.[17]

In addition to primary care shortages, HRSA has designated areas of Mississippi with manpower shortages in dental and mental health services. While the more populated areas of the State have a sufficient supply of dentists, this is not the case in the rural areas where severe shortages exist. Accordingly, Mississippi has 140 dental health professional manpower shortage areas.[18] The severe shortage of dentists in the State has tremendous consequences for PLWHs for whom there are only three providers statewide. There are 41 mental health manpower shortage areas in the State as of 2014.[19] To eradicate these shortages, the State would need to add 51 additional mental health practitioners. Information from the consumer survey and comments from the focus group participants suggest a continuing need to support these services given severe service gaps.

While HIV medical providers are located in most areas, there are Health Districts, most notably in rural areas, which lack HIV medical providers. This absence creates access barriers for PLWH living in the more rural areas of the State. Provider choice is also a luxury unavailable to PLWH. Partially as a result of lack of patient choice, a number of focus group participants spoke of the lack of customer service, sensitivity, respect, and adherence to confidentiality requirements that exists at some care sites. Fear of disclosure and "not wanting people talking about my business" is a comment frequently heard with regard to clients' reasons for not receiving care.

Another problem cited regarding accessibility is that outside of Jackson most clinics are not open on a full-time basis. Most are reported to be open only two days a week. The lack of integration of all Community Health Centers and Community Mental Health Centers within the HIV provider network was

[16] www.countyhealthrankings.org/appmississippi/2016/overview
[17] Mississippi Department of Health, State Health Plan
[18] Ibid
[19] Kaiser Health Foundation, www.khf.org

also viewed as a gap. HIV providers believe that many of these primary, dental and behavioral health care sites are already treating PLWH and those at risk for HIV, and the lack of coordination with these clinics causes missed opportunities to test those at high risk, especially since these patients are already linked to the health care system.

Comments regarding service gaps for medical, mental health, dental and vision care are presented below; followed by comments dealing with confidentiality concerns and concerns related to customer service.

Focus Group Comments

Medical

- "HIV prevention services are not integrated into Community Health Centers."
- "I know there are still a number of people in the medical community who shy away from prevention efforts because they still believe there is a high requirement for HIV counseling if you decide to screen."
- "I don't believe there are a lot of prevention messages in the private sector of the State. The CDC recommended HIV testing on wellness visits – I don't think that message has been taken up well by family practitioners. There is still reluctance on the part of the primary care providers to bring up the topic."
- "Community Health Centers do not regularly test. They have HIV clients but don't know it. If patients are accessing dental and vision they are doing it there."
- "We have no available dental or vision care providers in my area. We have mental health services [non-Ryan White provider]. We have a dearth of infectious disease doctors in the State."
- "There is a massive deficit in gay men's sexual health services."
- "In terms of HIV medical care there's just not enough people in enough areas; people don't have a choice of providers."
- "As a State there are rural areas that do not have access to all services."
- "Most of our clinics are only open two days a week."
- "The Ryan White clinics we have are great but there aren't very many of them."
- "We have limited access to services because we have a limited number of medical providers."
- "HIV prevention and treatment has been treated by the broader medical community as not their problem, so it's not integrated into general medical practice."
- "North Mississippi is a desert; Jackson has a significant presence with [*provider agency*]."

Mental Health

- "Mental health is a problem statewide and HIV clients are truly suffering from a lack of mental health services."
- "Mental health is a huge issue because of the people we have in shelters. There's maybe a handful that don't have mental health issues along with their HIV and substance abuse."
- "Our county mental health system in Mississippi struggles . . . it can take two months to see a counselor and then for the next appointment they will probably see a different one. And so each time they go they get re-traumatized by having to tell their story again."
- "Mental health is very lacking. The State does a poor job of providing comprehensive and ongoing mental health care. State-funded mental health centers are underfunded, under-

resourced, and in particular there's a lack of inpatient and outpatient substance abuse treatment centers available for people who are uninsured or underinsured, and Mississippi has the highest uninsured rate in the country, so that's a significant problem."

- "Mental health is really bad, we have community mental health centers that are difficult to work with and they can't see somebody if they're not from their region."
- "Mental health is abominable. We don't have sufficient professional counselors to deal with some of the more serious clinical issues. Isolation and depression are serious issues that are not being addressed in a timely manner."
- "The cost of mental health services is very high and Ryan White does not cover mental health services, so they have to be referred elsewhere."
- "With respect to mental health care there are a number of providers that will refuse to treat LGBTQ."
- "People with mental health issues have a higher rate of contracting HIV, and people who have HIV have a higher rate of mental health issues. We really do need to pay attention to mental health issues. I don't think the issue is adequately addressed."

Dental

- "There is a dentist in Jackson who works with the Health Department, he has a very large practice, people drive here to see him from all over the State."
- "Dental is a huge problem for people who are positive . . . you can have your teeth extracted but there's no funding to get those chompers back in – we have a lot of toothless people."
- "Dental care is spotty and there's an overall lack of good dental care for PLWH."
- "Dental care is really tough; there are only a few sites that do dental care."
- "We don't have good dental services, there's no political will to provide dental services with Ryan White money."
- "I only know of two Ryan White-funded dental clinics in the State."
- "There are only three dental providers that are dedicated to treating PLWH; so this part of health care is tremendously underserved. This is a missed opportunity for prevention as dental screenings could help identify new infections."

Vision

- "There is no vision care paid for by Part B, that I am aware of. Some of our patients need glasses but can't afford them."
- "Vision is not covered under ADAP or Ryan White so we have to refer them out to a clinic that might have a sliding fee scale or payment plan. The ones that don't have income can't afford to get the services."

Confidentiality and Customer Service

- "We need to teach people how to really communicate with each other because if they don't know how to place themselves in those person's shoes they will never know. If you go inside of a clinic and feel like the receptionist has a nasty attitude, I think it starts there – the patient is turned off and that attitude goes on throughout the clinic."
- "Marginalized populations: gay people, sex workers, addicts, Blacks are used to experiencing oppression and don't trust the Health Department. What would help is going to local CBOs which appear to be more compassionate."

- "There are a lot of trust issues, which is not to say that confidentiality is going to be broken by the Health Department, but that's the perception in the community and that's a perception we're trying to change."
- "Customer service, attitudes . . . make it so people want to come back and get care."
- "The Health Department is responsible for partner notification. They are also responsible for linking people to care, but the community sees them as the sex police and hide from them."
- "The Health Department is perceived as an institution that cannot be trusted and cannot deliver the thing that they say they are – confidentiality and counseling."
- "Oftentimes in clinical settings, front line staff are not properly trained on HIPAA and on how to deal with various populations – cultural competence and sensitivity. Those make a huge difference in retaining people in care because once a person comes in they can have the best experience in the world with the provider, but if the front line staff is terrible it may impact care."
- "Stigma and the likelihood of people worrying about confidentiality plays a huge role in retention in care."

BARRIERS TO HIV PREVENTION CARE SERVICES

Social and Structural Barriers

Mississippi ranks second in terms of overall poverty rate at approximately 23%, compared to a U.S. rate of 16%. Residents of the Jackson MSA fare somewhat better with poverty levels at nearly 20%. In comparison to the general population, survey respondents have higher poverty rates, lower rates of insurance, and are more likely to represent minority populations. Educationally, an evaluation of school performance finds that Mississippi ranks second to last (50 out of 51 states and the District of Columbia) in terms of academic achievement.[20]

While survey respondents have similar educational levels compared to the general population of the State and the Jackson MSA, they have higher unemployment, lower median income levels, and most lack insurance coverage as noted in the tables below.

Education

- Nearly 18% of all consumer survey respondents from Mississippi fail to complete high school.
  - Thirty-four percent complete high school, and an additional 34% have some college or had graduated from a community college, and 11% completed college or postgraduate training.
- Thirteen percent of survey respondents in the Jackson MSA had not completed high school.
  - Thirty-six percent of respondents completed high school, and 35% have some college or had graduated from a community college, and 9% completed college or postgraduate training.

[20] Jackson Free Press, January 8, 2016.

Table D.5
Educational Level
Mississippi State and Jackson MSA Consumer Survey

Educational Level	Mississippi State Consumer Survey n=319		Jackson MSA Consumer Survey n=130	
	#	%	#	%
8th Grade of Less	14	4.4%	2	1.5%
Some High School	42	13.2%	15	11.5%
High School Graduate/GED	107	33.5%	47	36.2%
Technical/Trade School/Vo Tech	12	3.8%	8	6.2%
Some College/Community College Grad.	109	34.2%	46	35.4%
College Graduate	29	9.1%	9	6.9%
Post-College	6	1.9%	3	2.3%

Educational Attainment				
	No High School Diploma	High School Graduate/ GED	Some College, Associate's Degree	Bachelor's, Professional, or Graduate Degree
Mississippi	18.1%	30.2%	31.3%	20.4%
Jackson MSA	13.9%	25.3%	31.8%	28.9%

Income

- Sixty-five percent of survey respondents from Mississippi have incomes of $0 -- $11,999.
  - Only 2% have incomes over $50,000.
  - Nineteen percent have incomes between $12,000 -- $23,999.
  - Ten percent have incomes between $24,000 -- $49,999.
- More than two-thirds of consumer survey respondents in the Jackson MSA have incomes between $0-$11,999.
  - Only 2.3% have incomes over $50,000.
  - Sixteen percent earn between $12,000 -- $23,999.
  - Ten percent have incomes between $24,000 -- $49,999.

Table D.6
Income Level
Mississippi State and Jackson MSA Consumer Survey

Income Level	Mississippi State Consumer Survey n=319		Jackson MSA Consumer Survey n=130	
	#	%	#	%
$0 No Income	93	29.2%	38	29.2%
$1 - $11,999	113	35.4%	49	37.7%
$12,000 - $23,999	60	18.8%	21	16.2%
$24,000 - $49,999	33	10.3%	13	10.0%
$50,000+	6	1.9%	3	2.3%
Declined to Answer	14	4.4%	6	4.6%

Median Household Income and Population Below Federal Poverty Level		
	Median Household Income	**Below Federal Poverty Level**
Mississippi	$ 39,464.00	22.6%
Jackson MSA	$ 45,366.00	19.9%
Source: U.S. Census Bureau ACS 2014		

Race/Ethnicity

HIV not only impacts low income communities disproportionately; it also impacts Blacks to a greater extent.

- Blacks are 36.7% of the population of Mississippi, but 74% of PLWH in the State.
- Blacks are 47.3% of the Jackson MSA, and 81.2%of PLWH from this area.

Table D.7
Race/Ethnicity
Mississippi State and Jackson MSA
General Population and PLWH

POPULATION MISSISSIPPI AND JACKSON MSA							
	Hispanic	**American Indian / Alaskan Native**	**Asian Non-Hispanic**	**Black Non-Hispanic**	**Native Hawaiian / Pacific Islander**	**White Non-Hispanic**	**Multiple Races**
Mississippi	2.8%	0.4%	0.9%	36.7%	0.0%	58.3%	0.9%
Jackson MSA	2.1%	0.2%	1.0%	47.3%	0.0%	58.6%	0.8%

PLWH							
	Hispanic	**American Indian / Alaskan Native**	**Asian Non-Hispanic**	**Black Non-Hispanic**	**Native Hawaiian / Pacific Islander**	**White Non-Hispanic**	**Multiple Races**
Mississippi	2.3%	0.1%	0.2%	74.2%	0.0%	20.1%	2.8%
Jackson MSA	1.8%	NR	NR	81.2%	NR	14.3%	2.7%

Employment Status

- Twenty-six percent of survey respondents from Mississippi are working full-time.
  - Ten percent are working part-time and 6% were working occasionally.
  - Twenty-five percent are not working and not looking.
  - Twenty-six percent are not working but looking.
- Thirty percent of survey respondents in the Jackson MSA are working full-time, and 14% are working part-time.
  - Sixteen percent are not working and not looking.
  - Twenty-seven percent are not working but looking.

Table D.8
Employment Status
Mississippi State and Jackson MSA Consumer Survey

Employment Status	**Mississippi State Consumer Survey n=319**		**Jackson MSA Consumer Survey n=130**	
	#	**%**	**#**	**%**
No, not looking	81	25.4%	21	16.2%
No, but looking	84	26.3%	35	26.9%
Occasionally	18	5.6%	10	7.7%
Yes, part-time	33	10.3%	18	13.8%
Yes, full-time	85	26.6%	40	30.8%
Declined to answer	18	5.6%	6	4.6%

State unemployment statistics available from the Department of Labor, Bureau of Labor Statistics put the current statewide unemployment rate as of June 2016, at 5.9%.

Insurance

- Consumer survey respondents from Mississippi are a highly uninsured population. More than two-thirds reported no insurance.
- Seven out of 10 consumer survey respondents have no insurance in the Jackson MSA, a slightly higher percentage than statewide.

Table D.9
Type of Insurance Coverage
Mississippi State and Jackson MSA Consumer Survey

Type of Insurance Coverage	Mississippi State Consumer Survey n=319		Jackson MSA Consumer Survey n=130	
	#	%	#	%
Medicaid	101	31.7%	37	28.5%
Medicare	0	0.0%	0	0.0%
Private	0	0.0%	0	0.0%
None	218	68.3%	93	71.5%

According to the U.S. Census, 24% of Mississippi's population aged 18-64 are uninsured.

Focus Group Comments

- "When you talk about rural Mississippi it all boils down to high poverty levels. Oftentimes, people who need to get information from social media don't have a cell phone or data plan. If we just focus on social media, we need to remember the ones who don't have access to it."
- "Poverty is a problem. They have to work 20 hours a week or they will be cut off the SNAP program."
- "People don't look at poverty as something to be addressed, they just say patients are non-compliant."
- "First things they ask is how much is this going to cost – how are they supposed to go to the doctor?"
- "Taking time off from work to see a doctor can be a problem."

Key Informant Comments

- "People don't go to the doctor, or they drop out-of-care because they had to make financial choices."
- "Practical things – transportation, money for the initial visit, part of what is all wrapped up in it is poverty and it doesn't have a whole lot to do with HIV. I think an awful lot of what we're seeing as far as people not participating in their care has more to do with their status in life, not their HIV status."
- "Stigma prevents people from accessing care and receiving prevention messages. The poverty level is high and the education level is low. All those things get in the way of prevention

messages in accessing care. Although care is available for the uninsured through the Ryan White program, this fact is either unknown or stigma associated with the diagnosis still keeps a lot of people out of care."

- "There are those who have tested positive and are not in care – one of the things that keeps them out of care is lack of insurance . . . the average person is probably not aware that there are sites that they can go to and receive care."

Federal, State and Legislative Policy Barriers

Stigma is particularly insidious in Mississippi, especially in the Black community where it often is associated with religious beliefs and sexual identity. Fear of disclosure and fear of being disowned by parents was a frequently cited reason preventing young MSM from following through with medical appointments.

Mississippi has criminal laws against transmission of HIV that could result in criminal prosecution. It is a felony to knowingly expose another person to HIV. There is a belief among HIV advocates that State laws specific to HIV transmission serve as poor public health policy and deter people from testing and from disclosing their contacts.

A Religious Accommodation Act was due to go into effect on July 1, 2016 but on June 30th a U.S. District Court Judge issued a preliminary injunction blocking the law. The legislation which promises to protect people who are opposed because of religious opposition to same sex marriage, extramarital sex and transgender from punishment if they refuse to provide services to others on these grounds. Opponents of the Mississippi law see it as State-sanctioned discrimination toward the LGBTQ community.

Correctional Policies

Mississippi State law requires correctional facilities to test inmates for HIV and other communicable diseases. The Mississippi Department of Corrections (MDOC) may also test inmates under certain circumstances while they are incarcerated, but does not test upon release from prison. Other circumstances include those at high risk, inmate request, court order, clinical indication or involvement in an incident.[21] All Mississippi inmates attend classes on HIV prevention during the admission and orientation.[22]

Until February 1, 2014, Mississippi did dispense condoms to married opposite sex inmates during conjugal visits. The Commissioner of the Mississippi Department of Corrections cited the expense of the program and the potential for creating single parents as the reasons for terminating the policy.[23]

Comprehensive Sex Education in Schools

Mississippi does not appropriate State funds for pregnancy, STD and HIV prevention. According to law, schools are not required to teach sex education at all. However, if they choose to teach sex education the law requires that abstinence be the standard taught. While instruction on contraception is allowed, it must include information on failure rates and diseases not protected against by contraceptives.

[21] http://aidsite.org/guide/hiv-care-correctionalsetting
[22] www.law.umich.edu/special/policyclearinghouse/documents/Mississippi_Department_of_Corrections_Inmate_Handbook.
[23] http://natin.time.com/2014/D1/13/mississippi-ending-conjugal-visits-for-prisoners/

Demonstrations of how to use contraception are not permitted and schools cannot dispense contraceptives to students.

Despite an emphasis on abstinence, statistics from the Youth BRFSS survey indicate that 48% of Mississippi high school students had sexual intercourse, compared to 41% of U.S. teens in 2015. Mississippi teens had the third highest teen birth rate in 2012.[24] In 2013, Mississippi had the fifth highest rate of Chlamydia and fourth highest rate of gonorrhea among young people ages 15-19.[25]

Coordination of State Entities

There are a number of State departments and divisions whose responsibilities do intersect with the needs of PLWH, and those at risk for HIV. These entities include but are not limited to the Mississippi Division of Medicaid, the Department of Corrections, the Department of Education, the Department of Mental Health, the Mississippi Insurance Department, and the State Licensing Boards (Medicine, Nursing, Dentistry, etc.). The issues that confront the PLWH are wide-ranging and not all are under the purview of the State Department of Health. Like most large organizations, the various departments are autonomous and relationships between the divisions of State government are largely informal. The kind of changes that will be needed to implement the National HIV/AIDS Strategy for the United States in Mississippi will require enhanced cooperation and communication between these various intersecting departments of State government.

Legislative Barriers

Strict State procurement laws and a historical reliance on using internal resources to support public health services has led to unobligated monies for HIV services. The Health Department has a long history of using its own infrastructure to provide services rather than outsourcing them to external organizations. State procurement laws require at least two bid quotes for contracts between $5,000-$50,000 and a competitive bid for projects in excess of $50,000. To outsource larger grants to outside organizations would require the Department of Health to prepare well-written requests for proposals and to have CBOs or other organizations in Mississippi that can submit strong proposals for funding.

This would, in turn, require that the Department staff be trained and have a process in place to evaluate and monitor sub-contractors and sub-awardees, which increases administrative costs. Changing this operating structure will require that staff are trained and assigned new responsibilities for monitoring and evaluating the volume and quality of services delivered. Thus, ample time and experienced staff is needed to outsource large amounts of monies for prevention, testing and treatment. The major impediments to unobligated money has been unfilled staff positions and over-estimated service volumes for testing or other service contracts.

Federal and State Insurance Coverage Laws

The U.S. Department of Health & Human Services reports that as of February 22, 2016, 104,538 Mississippians were enrolled in health care insurance through the Affordable Care Act Marketplace. While states have the opportunity to expand Medicaid to individuals with incomes at or below 133% of

[24] www.NCSl.org/research/health/teen-pregnancy-in-mississippi.aspx
[25] www.advocatesforyouth.org/storage/advf4/documents/young-people-in-mississippi.pdf

the poverty level, 20 states, including Mississippi, decided not to expand Medicaid. This decision not to expand Medicaid has restricted access to these benefits to an estimated 165,000 uninsured people.

To be eligible to receive Medicaid in Mississippi parents of dependent children (three people) must be living at 27% of the Federal poverty level, ranking the State 46th among the states and Washington D.C. for the most restrictive income requirements. As a result, the failure to expand Medicaid, the Kaiser Foundation anticipates that 37% of all non-elderly adults in the State fall in the coverage gap and remain uninsured.[26] Comments regarding barriers due to Federal and State legislative policies are presented below.

Focus Group Comments

- "If they have insurance they have to pay co-pays."
- "Some people have gotten the Affordable Care Act, regrettably it's not a lot of people but they can't afford it and it's not good coverage."
- "Lack of insurance."
- "Insurance companies have put all HIV medications on this specialty tier where it's not a $20 co-pay anymore, it's $40."

Key Informant Interview Comments

- "Lack of health insurance coverage; lack of sexual education."
- "About 70% of people on Ryan White would be eligible for Medicaid if it were expanded."
- "There is no reliable way to get the right messages to the right people and since we don't have Medicaid expansion, our high risk population doesn't have health insurance and that further limits their capacity to engage in health care systems."
- "As far as knowledge-based prevention, we have a very aggressive puritanical view of sexuality that limits sex education in the schools and also in general."
- "The public is broadly ignorant. In schools there's a lot of reluctance to have sex education. There is not really any public support from the legislation and government because it's not a priority for them or it's not their problem."
- "HIV disclosure laws repel people from testing centers and prevention services . . . It's bad public health. Our HIV-specific laws create distrust in institutions, a fear of getting tested and being punished."

Health Department Barriers

The Mississippi State Department of Health STD/HIV Office is critically understaffed due to non-competitive salaries. The department is without a Financial Director and has been unable to hire one for several months. The department lost its Quality Director to a higher paying position within the State, and its Case Management Director recently retired. Currently, the State will only allow programs to hire staff at the starting salary rate for the position, which is extremely low. This also serves to limit the pool of eligible candidates to those without significant prior experience. There have been no raises for State employees for the last seven years. These issues suggest that critical staffing shortages may continue to persist and further hamper efforts to maintain proactive leadership in prevention and care initiatives.

[26] HIV Infrastructure Study, Jackson, Mississippi, May 2015, http://southernaidsstrategy.org

State DIS workers are assigned to link newly diagnosed persons to care; and as one informant suggested, "They should assist the client in keeping that appointment"; however, staffing shortages and increases in STDs may make this task difficult to achieve.

Mississippi is a conservative state, often described as the "Buckle of the Bible Belt". Religion and race are deeply rooted in the social, political and cultural landscape of the State, a factor that can lead to stigma around HIV, especially in the context of transmission modes (homosexual or non-marital sex).[27] Given this social and political context there is little political support or advocacy to tackle the issues of HIV, or related issues of sexuality and health disparities. However, some study participants believe that some minor changes have taken place and will take place, but at a slow pace.

Key Informant Comments

- "HIV advocacy is mostly lacking in Mississippi. Although over the last 5-10 years there's been some increased activity in that regard. Still, HIV support groups, community-based organizations, don't have nearly the loud voice that you might find in California, and so the support groups and CBOs are located in pockets in the State, they tend to be in a few metropolitan areas."
- "Advocacy is a huge gap. Primarily, self-advocacy – it is difficult to get people who are positive to participate."
- "I would like to see prominent MSMs in the community lead by example, to say 'I got tested; let's all get tested'."

Program Barriers

The Mississippi State Department of Health STD/HIV offices is a Part B Ryan White recipient. The office received $14,688,110 in Federal funding in 2016. In 2013, the most recent year for which all states' data are available, Mississippi ranked 11th in terms of the estimated rate/100,000 of adults and adolescents living with HIV, and ranked 37th in terms of Federal HIV/AIDS Grant Funding per adults and adolescents living with HIV/AIDS.

The bulk of prevention dollars spent in the State is used to fund testing, condom distribution, and, more recently, the expansion of PrEP services. The lack of funding leaves limited resources for educating the general public or even those at the highest risk for infection. There is at least one innovative outreach program targeted to young Black MSM which has trained community health workers to do outreach into this community. While it is too early to measure the impact of this program, these outreach workers are tasked with bringing patients in for testing and supporting them through the linkage to care process. Proponents of the program believe the program will be able to demonstrate its effectiveness.

[27] State Healthcare Access Research Project, Amy Rosenberg, Emily Broad, Rachael Mehisak, Stacy Clark and Robert Greenwald, November 2010.

Table D.10
PLWH by State, 2013

Region		Federal HIV/AIDS Grant Funding Per Adult/Adolescent Living with HIV/AIDS $	Rank (1 is highest)	Estimated Number of Adults and Adolescents Living with an HIV Diagnosis #	Rank (1 is highest)	Estimated Rate (per 100,000) of Adults and Adolescents Living with an HIV Diagnosis Rate/100,000	Rank (1 is highest)
	United States	**$ 3,300**		**931,526**		**353.20**	
South	**Mississippi**	**$ 3,002**	**37**	**9,036**	**26**	**366.90**	**11**
South	Alabama	$ 3,545	23	12,025	20	297.40	20
South	Arkansas	$ 2,634	47	5,006	33	204.40	27
South	Delaware	$ 3,520	25	3,053	34	392.20	8
South	District of Columbia	$ 5,804	5	15,173	18	2,695.80	1
South	Florida	$ 3,130	35	101,452	3	606.10	4
South	Georgia	$ 3,155	33	42,067	5	512.70	5
South	Kentucky	$ 2,994	38	5,849	29	159.40	35
South	Louisiana	$ 3,659	19	19,201	13	502.20	7
South	Maryland	$ 2,847	41	31,890	9	641.10	3
South	North Carolina	$ 2,713	44	26,770	10	326.30	16
South	Oklahoma	$ 2,695	45	5,433	31	171.80	32
South	South Carolina	$ 2,835	43	15,550	16	389.30	9
South	Tennessee	$ 3,345	29	16,133	15	297.20	21
South	Texas	$ 2,836	42	73,959	4	345.80	12
South	Virginia	$ 2,605	48	21,774	11	314.50	18
South	West Virginia	$ 3,141	34	1,664	42	105.30	41
Midwest	Illinois	$ 3,603	21	34,681	7	322.90	17
Midwest	Indiana	$ 2,369	51	9,595	25	176.40	31
Midwest	Iowa	$ 3,828	13	1,952	40	75.90	46
Midwest	Kansas	$ 2,538	49	2,807	35	118.40	38
Midwest	Michigan	$ 2,913	40	15,439	17	185.40	30
Midwest	Minnesota	$ 3,675	18	7,306	28	162.40	33
Midwest	Missouri	$ 3,095	36	11,968	21	237.30	25
Midwest	Nebraska	$ 3,475	26	1,839	41	120.30	37
Midwest	North Dakota	$ 7,464	4	218	51	36.20	51
Midwest	Ohio	$ 2,447	50	19,441	12	200.50	28
Midwest	South Dakota	$ 5,772	6	494	47	71.30	47
Midwest	Wisconsin	$ 3,743	17	5,535	30	115.00	39
Northeast	Connecticut	$ 3,813	14	10,255	24	335.50	13
Northeast	Maine	$ 3,758	16	1,193	43	104.10	43
Northeast	Massachusetts	$ 3,612	20	18,839	14	329.00	15
Northeast	New Hampshire	$ 3,261	31	1,178	44	103.60	44
Northeast	New Jersey	$ 3,275	30	37,832	6	505.80	6
Northeast	New York	$ 3,574	22	130,691	1	784.10	2
Northeast	Pennsylvania	$ 3,522	24	32,547	8	299.60	19
Northeast	Rhode Island	$ 4,984	9	2,168	39	240.10	24
Northeast	Vermont	$ 7,514	3	445	48	82.20	45

(table continues)

Table D.10
(Continued)

Region		Federal HIV/AIDS Grant Funding Per Adult/Adolescent Living with HIV/AIDS $	Rank (1 is highest)	Estimated Number of Adults and Adolescents Living with an HIV Diagnosis #	Rank (1 is highest)	Estimated Rate (per 100,000) of Adults and Adolescents Living with an HIV Diagnosis Rate/100,000	Rank (1 is highest)
West	Alaska	$ 5,770	7	626	46	104.30	42
West	Arizona	$ 2,932	39	13,284	19	242.80	23
West	California	$ 3,401	28	119,845	2	376.20	10
West	Colorado	$ 4,650	10	11,624	22	266.00	22
West	Hawaii	$ 3,875	12	2,430	38	205.60	26
West	Idaho	$ 5,447	8	856	45	65.70	48
West	Montana	$ 8,264	1	396	49	46.40	50
West	Nevada	$ 2,678	46	7,689	27	331.80	14
West	New Mexico	$ 3,790	15	2,677	36	155.70	36
West	Oregon	$ 3,978	11	5,383	32	162.30	34
West	Utah	$ 3,402	27	2,565	37	114.60	40
West	Washington	$ 3,228	32	11,441	23	196.50	29
West	Wyoming	$ 7,574	2	249	50	51.60	49

Notes: See http://kff.org/hivaids/state-indicator/federal-grant-funding-per-person/ for notes and sources.
Notes: See http://kff.org/hivaids/state-indicator/estimated-rates-per-100,000-of-adults-and-adolescents-living-with-an-hiv-diagnosis/ for notes and sources.
Notes: See http://kff.org/hivaids/state-indicator/estimated-numbers-of-adults-and-adolescents-living-with-an-hiv-diagnosis/ for notes and sources.
Notes: See http://kff.org/hivaids/state-indicator/total-federal-grant-funding/ for notes and sources.

Focus Group Comments

- "I think a major barrier to assisting clients is the limited capacity of agencies to service them."
- "Funding is a barrier to getting things done . . . we understand what needs to be done, but we can't afford it."
- "We have a critical need for money. That's something that's going to have to happen at the federal level. The money needs to follow the disease and it's not."
- "Pull more providers into the network, more availability of providers and options for patients."
- "We all communicate with each other. We have the same goals, just lack the availability to do more."
- "There are not enough providers. Mississippi is mostly rural and for the most part people in these areas are traveling long distances to get care."
- "There are a couple of areas in Mississippi that do not have Ryan White funded sites. Those are mainly in the area south of Tupelo, which encompasses Starkville, Columbus and Meridian. . . . Then, in the southwestern corner south of Natchez, also has no Ryan White care site."

Key Informant Comments

- "There is no opportunity or funding to do outreach in the community – it's limited.
- "There is not a lot of State money dedicated to prevention. Federal funds are limited in terms of how they can be used."
- "I think HIV social workers and DIS workers work well in getting patients seen and getting them tested. The downfall is after I interview them I find myself with the same barrier – lack of access to services. I'm in a rural area."
- "We need clinical care sites in the areas that are lacking them and that is within the system to fix. Individual clinics can't do anything about getting more insurance or getting better education or improving the per capita income for the clients they serve. Those are more general social problems."
- "We need more funding just to have people dedicated to linking people to care and we should expand the definition of linked to care from two visits to one year."
- "The Health Department understands that more people need to be in care and that they're the entity best set up to do that, however, they're underfunded and understaffed. So, once they test someone, they're asking potential care sites to be involved with getting the patient to come to the clinic and show up for the first appointment. The problem is the care sites haven't met the patient yet. Most clinic staff believe it's not the right approach and I agree. I think the Health Department personnel should assist the client in keeping that appointment, but they say [HD] they don't have the staff to do that."

Service Provider Barriers

The overall number of HIV program providers in Mississippi represents a relatively small group of organizations with the majority of providers located in the Jackson MSA. HIV providers generally work well together albeit the territorialism and competitiveness that occurs when limited dollars are at stake. PLWH often need services outside the realm of services funded by Ryan White organizations and ASOs. The receipt of these services are arranged via informal referral arrangements between providers. Efforts to engage non-Ryan White-funded agencies in more meaningful ways have met with little success.

Mental health services are lacking in the State and especially challenging to access for those without insurance. HIV providers who offer mental health services, including University of Mississippi, Open Arms and Grace House are well integrated into the system of care but coordination and collaboration with Community-Based Mental Health Services, which are available in 15 districts of the State, are less well-integrated into the system of care.

Participants are concerned about the lack of routine testing by non-Ryan White-funded health clinics, and with local hospitals and emergency rooms, especially those located in health districts with high HIV incidence rates. Many providers see this as a lost opportunity to diagnose people at risk for HIV. Advocates for PLWH feel that efforts to reach out to PLWH and ASOs would be beneficial to better meet the prevention and care needs of this community. Additionally, coordination between Ryan White and non-Ryan White-funded agencies (CBOs, ASOs and the faith community) will be essential to ensuring that prevention and care needs are met for PLWH.

Participants raised concern with the level of testing and reporting of HIV+ diagnoses by private practitioners in the community and of their awareness and receptivity to prescribing PrEP for their private patients. The overall shortage of physicians in Mississippi suggests that private physicians can be selective in terms of the insurances they will accept. That said, enhanced communication with the Medical Society might encourage practicing physicians to begin asking their patients about sexual activity, PrEP, and ensure referral of private patients to supportive services.

Focus Group Comments

- "We have case conferences and a close relationship with providers."
- "There is not a lot of collaboration across the State."
- "We have a really good relationship with the Health Department."
- "The Planning Council is the major collaborative."
- "We work together, but there are some turf issues and so if I'm doing this segment of outreach and prevention, we need to be able to provide a holistic service to all clients that we see and not be concerned that this isn't my segment."
- "I know several people from here and they go out-of-state and use someone else's address."
- "The Caucasians are going to private doctors and they're not reporting the information . . . it gets buried."
- "The ones that go out-of-state and give false addresses or use someone else's address, they don't want to be found, whether or not the labs, doctors, report."
- "The Caucasians, sometimes I wonder . . . I don't think they're being reported . . . They're having sex too."
- "We have physicians that will tell patients that the only thing the State requires is that you get post-test counseling and you don't have to disclose."

Key Informant Comments

- "I'm not sure providers coordinate well together, but I know for instance the clinic and coordinators of clinics coordinate well together. They talk quite a bit. Outside of consultations, I don't believe there is any collaboration between providers. The coordinators talk about different clinical issues and improvements and addressing issues. They are a support system for each other. Most of our HIV clinics are Ryan White so it's a close knit community."
- "I'd say we coordinate well with Ryan White programs; we're helpful to one another, share resources, and quality projects and results, we meet by phone monthly, in-person quarterly – care and services, meetings. Any other providers, we have no communication with them and they're providing services as well and I have no tracking information."
- "Make testing an opt-out issue for clinics around the State; it would be a great opportunity."
- "We should collaborate with other organizations to see what resources we could share to get patients transportation, mental health."
- "The State works on collaboration but there is a reluctance of local agencies to collaborate because of territorialism."
- "There is not nearly enough community involvement."
- "There has traditionally been territorialism, but I think that's getting better; there's more room for cooperation."
- "I think we work very well together. There are tensions between organizations at times from competitive funding. Funding is limited; jobs and lives depend on it."

- "Some groups work extremely well together and other groups don't work as well together as they should. It's gotten better. It happens because of limited funding."
- "I would like to see greater participation from PLWH on the Planning Council to have a larger voice in policy making."
- "I think there is a lack of significant input from people who are positive."

Care Continuum

Despite resource shortages in personnel and funding, most providers are highly dedicated individuals providing quality medical care. Most see value in the ADAP program which provided services to approximately 68% of survey respondents from Mississippi, and 60% of those residing in the Jackson MSA.

Approximately 80% of survey respondents report being linked to care within three months of diagnosis and 90%-95% reported seeing a physician, getting a CD-4 test, or taking medication in the last year, which corresponded to providers' belief that once people were in the system, they were able to receive HIV medical services. Providers' concerns were more directed to the ability to get HIV+ individuals who are unaware of their status into testing, to link newly diagnosed patients to care, and to retain high risk patients in the care they needed. Enhanced cooperation and collaboration between Ryan White providers, ASOs, CBOs, non-Ryan White providers and the Health Department is seen as essential to ensuring this occurs.

To assist in linkage to care efforts, MSDH is training DIS workers to link newly diagnosed patients to care sites and assigned case workers to track down patients who have been lost to care. It is too early to tell if this reorganization of services will improve services for PLWH or if it will work in each jurisdiction. There are concerns raised by some that DIS workers may lack skills and insights into identifying client barriers and ensuring that basic housing, transportation and support needs are met so that the consumer can successfully enter into the care system. Others see improvements in the timeliness with which patients are being linked to care. The Jackson Medical Mall Foundation's "Care 4 Me" Program has trained 40 community health workers to go into the community to encourage young Black MSMs to get tested and to provide them with support as they begin their treatment.

Consumer Survey

- Eighty percent of consumer respondents from Mississippi reported seeing a medical care provider within three months of diagnosis.
- Seventy-seven percent of consumer respondents from the Jackson MSA reported seeing a medical care provider within three months of diagnosis.

Table D.11
After diagnosis, how soon did you have your first visit with a Medical Care Provider?
Mississippi State and Jackson MSA Consumer Survey

Timeframe	Mississippi State Consumer Survey n=319		Jackson MSA Consumer Survey n=130	
	#	%	#	%
The next day	67	21.0%	31	23.8%
Within 1-3 months	189	59.2%	70	53.8%
Within 4-6 months	23	7.2%	18	13.8%
Within 7-12 months	12	3.8%	1	0.8%
One year or more	26	8.2%	8	6.2%
I haven't seen a doctor or medical professional	2	0.5%	2	1.5%

- Ninety percent of Mississippi survey respondents took HIV medications in the last year, 96% saw a health care provider for HIV care, and 94% had a viral load or CD-4 test in the last year.
- Eighty-nine percent of Jackson MSA survey respondents took HIV medications in the last year, 93% saw a health care provider for HIV care, and 92% had a viral load or CD-4 test in the last year.

Table D.12
Have you taken HIV medications in the last 12 months?
Mississippi State and Jackson MSA Consumer Survey

HIV medications taken in the last 12 months	Mississippi State Consumer Survey n=319		Jackson MSA Consumer Survey n=130	
	#	%	#	%
Yes	288	90.3%	116	89.2%
No	27	8.5%	12	9.2%
Don't know / Don't remember	4	1.3%	2	1.5%

Table D.13
Have you had CD-4 Count or Viral Load tests in the last 12 months?
Mississippi State and Jackson MSA Consumer Survey

CD-4 Count or Viral Load Test in the last 12 months	Mississippi State Consumer Survey n=319		Jackson MSA Consumer Survey n=130	
	#	%	#	%
Yes	300	94.0%	119	91.5%
No	15	4.7%	9	6.9%
Don't know / Don't remember	4	1.3%	2	1.5%

- Approximately 68% of all survey respondents report receiving Ryan White services or ADAP benefits.
- Nearly 58% of survey respondents in the Jackson MSA are receiving Ryan White services or ADAP assistance.

Table D.14
Did you get Ryan White or ADAP services in the last 12 months?
Mississippi State and Jackson MSA Consumer Survey

Ryan White/ADAP	Mississippi State Consumer Survey n=319		Jackson MSA Consumer Survey n=130	
	#	%	#	%
Yes	216	67.7%	75	57.7%
No	82	25.7%	46	35.4%
Don't know / Don't remember	21	6.6%	9	6.9%

Out of Care Interviews

All of the out of care respondents indicated one of the reasons they have not seen a medical provider is because they didn't have enough money or insurance. Other reasons tied and ranking second included not feeling sick, because they were afraid or in denial about having HIV and because they didn't want anyone to know their HIV status.

In probing the issues of stigma in greater detail all said they were careful about who they told they had HIV and most were worried that people they told would tell someone else. Most interviewees admitted to being hurt by how people reacted to learning they were HIV+ and believe that most people are rejected when other people find out they have HIV.

Focus group and key informant consumers related to issues they encounter with regard to the care continuum and suggestions for improvement are presented below.

Focus Group Comments

- "Our strengths include the availability of medications and also well-trained providers."
- "We make sure patients get into care when they relocate."
- "When someone tests positive they should be linked to care immediately, not in a few days."
- "There is not a waiting list or restriction involving ADAP in Mississippi – all medicines are available."
- "I'd give general HIV care an 'A'. If we can get them in care, there is good care. The challenge is getting them in."

Key Informant Comments

- "I think the HIV social workers and the DIS workers working together in getting patients seen and tested works well."
- "Once someone is in the system, there is a pretty good network to ensure people have good access to care."

- "If people get enrolled in the Ryan White Program, they do really well; getting to that point is the real challenge."
- "We're really good at making Ryan White and ADAP go as far as possible as a State."
- "We have more problems with our patients then with the system and one of the biggest barriers is the patient's acceptance."
- "Acceptance is one of the things that delays people from getting tested."
- "The DIS connects them to us for care, and there's a huge breakage there . . . frequently they don't show up to their appointment even though the Health Department is in contact with us and the patient, linkage is the breakdown."
- "If you happen to be in a Ryan White clinic there is a potential immediate link to care; however, if you are not [in a Ryan White clinic] when you test positive, then that's where people fall through the cracks because you are simply being referred to services; someone may or may not follow up with you."
- "For people in care I think pill fatigue or maybe more generally just care fatigue is a reality. It's common to see people start missing their appointments mainly because they are tired of the whole thing."
- "I think the weakness here is linkage and retention in care."
- "I think having a more active network of people who are positive who could participate in peer navigation and peer care would be helpful. There are only two support groups in the State of Mississippi that provide support for people living with HIV."
- "Linkage to care should be done by someone who does outreach in the community – an ASO, church, etc."
- "The Health Department needs to be more open to input from CBOs and ASOs in the community."
- "There should be a technological way to follow people who struggle to stay in care; give them a cell phone that buzzes as a reminder to take their medications."
- "The retention in care price, there's some control of that. We do have data to track down people who are out-of-care – so that's a piece that can be built on."
- "Use data-driven retention initiatives and case management."
- "Providers should support patients' efforts to become informed and proactive – find a way to provide a 'daily dose' of new information to them."
- "Having peer navigators, peers who go into the community and who have more knowledge of what the person is going through."
- "I think if we could find a way to connect with people every few days or once a week by offering support groups and information/education seminars, workshops and mental health support groups."
- "I think this new program we're rolling out with DIS and case managers working together has improved timeliness."
- "Establish improvement programs for medication adherence and viral load suppression with clinician feedback."

Client Barriers

Widespread poverty, housing insecurity, transportation, lack of insurance coverage, stigma, co-morbid conditions including behavioral health act as barriers to clients in accessing prevention and care services.

Survey respondents throughout Mississippi and in the Jackson MSA gave the need for help in paying for insurance, co-pays and deductibles as the number one need they have but are not getting. This is not surprising given that the majority of survey respondents earned less than $24,000 a year, and more than two-thirds were uninsured.

To assist clients with transportation, stipends and bus passes are available, as are services funded by Medicaid for consumers who are without a car or other reliable source of transportation, but the demand for these services outweighs the system's capacity to provide them. There are few sources of public transportation outside of the City of Jackson making transportation particularly difficult for those living in rural Mississippi. The lack of HIV medical care sites in District 4 and District 6, combined with the rural nature of the State, can mean travel to a care site is a whole day activity for PLWH.

Housing and housing instability rank second highest among Mississippi and Jackson MSA PLWHs in terms of services they need but are not getting. Additionally, 10% of Mississippi consumer survey respondents are accessing HOPWA funds, well below the number who say they need assistance. Grace House in Jackson has been providing housing for PLWH who are chronically homeless through the Federal HOPWA funding. Grace House was notified in May that its HOPWA grant is not being funded in 2016.

Stigma and fear of disclosure remains the top barrier for PLWH in seeking testing and care services. While HIV stigma exists across the State, it is most profound in rural areas where the small size of the community. The fear that everyone will know, makes PLWH reluctant to seek care anywhere near where they live. Focus group participants cite numerous examples of people traveling long distances or even out-of-state to receive care to avoid using a local clinic where someone they know might work. Many fear, and with reason, that seeking care locally could result in a breach of their confidentiality. Confidentiality concerns, real or perceived, are a huge deterrent for those at high risk.

HIV stigma is a complex phenomenon rooted in other forms of prejudice and discrimination, including racism, homophobia and classism. The lack of knowledge and low health literacy about HIV transmission leads to misinformation about the disease and how it is transmitted. Misinformation and ignorance fuels fear and discrimination. HIV stigma is deeply rooted in prejudice against homosexuality and informants spoke often of the perception in the general public that HIV is a "gay men's disease".

Minorities and low income populations are disproportionately impacted by both HIV and low literacy levels which can negatively impact access to care for people living with HIV. People with low literacy may not recognize the importance of early and consistent medical care or lack experience in navigating the health system.

Consumer Survey

- Fear of disclosure is the most mentioned reason for why it is hard to stay in care for survey respondents from Mississippi as well as those from the Jackson MSA.
  - The second most common barrier for Mississippi respondents is transportation, and wait for appointment too long or appointment time inconvenient ranked third.
  - Survey respondents from the Jackson MSA rank wait time too long or appointment time inconvenient as second, and the reason too depressed/other mental problems as third.

Table D.15
What makes it hard to stay in medical care or cause you to miss appointments?
Mississippi State and Jackson MSA Consumer Survey

Barrier	Mississippi State Consumer Survey n=319		Jackson MSA Consumer Survey n=130	
	#	%	#	%
Wait for appointment too long or appointment time inconvenient	52	16.3%	24	18.5%
I was worried someone would find out I'm HIV+	59	18.8%	31	23.8%
Trouble getting reliable transportation	54	16.9%	19	14.6%
Lack of childcare	12	3.8%	7	5.4%
Sometimes I feel too sick to go	43	13.5%	18	13.8%
I don't like/trust my doctor	22	6.9%	7	5.4%
Using street drugs or alcohol	19	6.0%	14	10.8%
Too depressed/other mental problems	50	15.7%	21	16.2%
Different doctor or health professional each visit	23	7.2%	5	3.8%
Staff doesn't speak my language	14	4.4%	6	4.6%
Insurance but out-of-pocket costs for care or medications too high	48	15.0%	0	0.0%
I don't understand why I need treatment or my treatment options	18	15.6%	4	3.1%

The majority of consumer respondents report getting medical care in the last 12 months; 96% in Mississippi and 98% in the Jackson MSA.

Table D.16
Have you been to a medical provider to get HIV care in the last 12 months?
Mississippi State and Jackson MSA Consumer Survey

Gotten HIV medical care in the last 12 months	Mississippi State Consumer Survey n=319		Jackson MSA Consumer Survey n=130	
	#	%	#	%
Yes	306	95.9%	121	93.1%
No	13	4.1%	9	6.9%
Don't know / Don't remember	0	0.0%	0	0.0%

- Mississippi consumer respondents who report not seeing a doctor in the past year gave the following reasons:
  - I don't want to think about HIV (46%).
  - Inconvenient clinic hours/locations (39%).
  - Can't afford care, insured but cost of care or medications too high, no reliable transportation, forgot appointments, lack of housing/homeless, too depressed or other mental problems, and "I was worried someone might find out I was HIV+" (31%).
- Consumer respondents' ranking of reasons for not seeing a doctor are similar in the Jackson MSA.

Table D.17
Reasons given by Mississippi survey respondents who did not see a medical provider in the past 12 months
Mississippi State and Jackson MSA Consumer Survey

Reason	Mississippi State Consumer Survey n=13		Jackson MSA Consumer Survey n=9	
	#	%	#	%
Can't afford care	4	30.8%	4	44.4%
Insured, but cost of care or medications too high	4	30.8%	3	33.3%
Inconvenient clinic hours/locations	5	38.5%	4	44.4%
No reliable transportation	4	30.8%	3	33.3%
Wait for appointment too long, or I am unable to get an appointment	3	23.1%	3	33.3%
Forgot appointments	4	30.8%	3	33.3%
I was not sick, so I didn't think I needed medical care	2	15.4%	2	22.2%
Other responsibilities were more important	3	23.1%	2	22.2%
Lack of stable housing/homeless	4	30.8%	4	44.4%
In jail	3	23.1%	3	33.3%
Don't want to think about being HIV+	6	46.2%	5	55.6%
Felt good/no need for care or treatment	3	23.1%	2	22.2%
I felt too sick	2	15.4%	1	11.1%
I did not know who to go to for medical care/couldn't find a provider	3	23.1%	2	22.2%
I don't like or trust my doctor	1	7.7%	1	11.1%
Using drugs or alcohol or relapsed	2	15.4%	2	22.2%
Too depressed/other mental problems	4	30.8%	3	33.3%
I was worried someone might find out I'm HIV+	4	30.8%	3	33.3%
Using alternative treatments	2	15.4%	1	11.1%
I didn't find a doctor or nurse who wanted to treat me	3	23.1%	2	22.2%
No really sure I'm HIV+	2	15.4%	1	11.1%
Faith in God – don't need medical care	2	15.4%	2	22.2%

The consumer survey also reviewed the use of alcohol, tobacco and drugs among PLWH.

- Tobacco use, marijuana and alcohol use are the top three substances reported used by survey respondents in both Mississippi and in the Jackson MSA.
  - Prescription drug abuse ranks fourth in both the State and MSA.
  - Cocaine/crack ranks fifth.

Table D.18
Substance Use
Mississippi State and Jackson MSA Consumer Survey

Substance	Mississippi State Consumer Survey n=319		Jackson MSA Consumer Survey n=130	
	#	%	#	%
Alcohol (15 or more drinks a week)	55	17.2%	32	24.6%
Tobacco (everyday / most days)	139	39.8%	63	48.5%
Cocaine / Crack	16	5.0%	9	6.9%
Heroin / Opiates	0	0.0%	0	0.0%
Methamphetamine / Stimulants	4	1.3%	3	2.3%
Marijuana	82	25.7%	43	33.1%
Club drugs (X, 6, Special K, etc.)	8	2.5%	4	3.1%
LSD / Acid or Hallucinogens	2	0.8%	1	0.8%
Hormones / Steroids	9	2.8%	4	3.1%
Prescription drugs (Oxycodone, Vicodin, Percocet)	25	7.8%	13	10.0%
I don't use anything	0	0.0%	0	0.0%

Community respondents' comments regarding barriers to care are provided below.

Focus Group Comments

Stigma

- "Stigma, people are scared to seek treatment – fear of repercussions of family, friends and neighbors."
- "A lot of it is stigma, a lot of it is sexual practice – they know what they're doing. They know they're having risky sex and know it's a possibility but they ignore it and don't do anything until they have an episode where they collapse and are taken to the doctor."
- "Being in the closet stops them from seeking care because they don't want their parents to know or their community to know they're gay."
- "I know of people who live in this county but are taken to another county to get care and medication because of stigma."
- "Finding them. We try to go to a variety of places where we might find them, but we're finding that people who are LGBTQ, specifically MSMs, really don't want to get tested. I think the

critical part is stigma. In Mississippi if you're male and you go to the Health Department there is no other reason than to get an STD test."

- "People don't want to access prevention services because they're either in denial or because of the stigma – they just don't want to know."
- "Some of the reasons they tell me they don't want to link to care are because either it could be time-consuming, they don't like the doctor or the clinic they're at, or they're embarrassed – a lot of things."
- "When you're trying to get people to come in to get tested, the problem I've heard is that the nurse is talking about my business in the hallway."
- "Nurses should not be talking about patients – stigma is hard enough to get over but to have providers with the same attitude."
- "If you access the health care system you should be treated fairly across-the-board, but there are barriers . . . the provider may be culturally different and not hearing what you're saying."
- "Young people fear of disclosure – I have one patient rather newly diagnosed and he said, 'If I tell my parents they will disown me.'"
- "Up in the rural area if a patient tests positive and doesn't have a supportive family they're going to put them in the back of the house or in the garage."

Transportation

- "One thing that's a barrier to linkage to care probably next to stigma our largest barrier is transportation."
- "Transportation is a problem for young people who may not have a car and don't want their parents to find out."
- "Transportation is an issue – some outreach workers drive clients to their doctor appointments."
- "Transportation is a huge issue; most patients don't own a car."
- "Transportation is terribly challenging . . . it's not readily available. Some benefit from Medicaid transportation but patients with Medicare are not eligible."
- "I have found in my area, retention is good if we can get them here and get them transportation."

Housing

- "A patient who lived in Hattiesburg needed housing and had to wait three months."
- "Homelessness – many more people need the services than we can serve."
- "Mental health issues, substance abuse issues, homelessness."

Literacy

- "Education is a barrier, people's ability to read and write and comprehend, and they rarely admit they can't read . . . they're embarrassed."
- "Patients start off on medications and once they feel good and aren't having many problems, they don't feel they need to keep taking medications."

Key Informant Comments

Stigma

- "Social stigma – being labeled, thinking that everyone knows my business."
- "Patients have to overcome stigma and their concerns about insurance and having to pay too much."
- "It's the stigma – what's attached to having HIV. That's the biggest problem in making an appointment. It takes them a while to absorb the knowledge."
- "Concern with stigma [are they looking at me funny . . . talking about me] whether the stigma is real or perceived . . . Issues of confidentiality, people knowing and fear that that person will tell someone they know, but the next clinic is three hours away so they don't go."
- "Some people it's just denial of the disease."
- "Stigma and people not wanting other people to know."
- "Young people are in denial, don't want to deal with it."
- "Stigma is always there."
- "We still have a lot of social stigma for high risk people, preventing them from having social support."
- "Stigma and the overall lack of awareness about health and wellness in the deep South. On this basis, the motivation to get tested isn't there."
- "Right now the focus area is young Black MSMs but I don't think we can negate that young Black women still need to be targeted. I think the services in Jackson are open and balanced but, I think if you go out to other parts, things like stigma, homophobia come into play. Stigma of testing and being positive, and internal and external stigma on behalf of providers, homophobia on behalf of providers."
- "There's a cultural disconnection – stigma is huge."
- "People are as stigmatized about getting tested as they are about being positive."
- "It's the stigma – what's attached to having HIV. That's the biggest problem to making an appointment. Takes a while to absorb the knowledge that it's true."

Transportation

- "Finances, travel, no one to depend on, or good transportation services, they don't' want people to know their business."
- "Rural areas have access challenges due to a lack of transportation."
- "The reasons for not keeping the appointment – troubles with transportation, lack of insurance, and concern that they are going to have medical bills to pay, HIV stigma itself, and I would say it takes the average person a period of time to adjust to learning that they were just diagnosed with HIV and they might not be ready to go to the clinic."

Behavioral Health

- "Mental health and substance abuse are untreated issues which impact the patient's ability to get into care and stay in care."
- "We don't talk enough about addiction and recreational drug use and HIV."

Housing

- "Access to housing and transportation; lack of social support."
- "Housing is a big issue."

- "The populations we're dealing with have a lot of psychosocial issues; people are on drugs; homeless."

Literacy

- "Education – having the right message; it doesn't work to say take your medicine it's good for you. Speak to people on their level of understanding."
- "Once they start medication, they think they feel fine and they're invincible, and when it runs out they don't have to take it anymore until they get sick again."
- "Health literacy is a component of why people drop out of care – understanding that just because you feel better doesn't mean nothing is wrong."
- "The hardest part is getting people to want to be educated about transmission."
- "I think the care continuum's weakness is it underserves gay men of all races. The system has done a lot to focus on the Black community, which is critical, but it's 100% focused and other populations are becoming indifferent. The wrong message is out there. Young white men think it's a Black problem"
- "I think we need to educate clients about how the process works. When they're tested they need to be given information about the end goal. I don't think this is well explained. This is what we need to do, this is the goal and this is the road map. Clients need to be educated about the system and providers need to be educated about the system. They are not educated about HIV in the public health sense in medical school. They know the biology side and the medications. So, give them the road map and tools so they can explain the system to clients."

Emerging Health Issues and Co-Morbidities

There is a considerable disconnect between providers' concerns with regard to emerging health issues and those most often cited by consumers. While HIV care providers are most concerned with the co-morbid STDs and Hepatitis C, and the propensity toward chronic diseases as patients age, the concerns most often mentioned by patients are concerns about emotional stress. This same concern is not always within the patients' awareness of their need for mental health/supportive services for emotional stress. A key reason may be the stigma related to a mental health diagnosis among some cultures.

- Emotional stress was the co-morbidity most reported by Mississippi survey respondents (36%) and Jackson MSA survey respondents (33%).
    - While STIs were second at 12%-13% of survey respondents impacted, this was a third less than those who reported emotional stress as a co-morbid condition.

Table D.19
Co-Morbidities or Infections
Mississippi State and Jackson MSA Consumer Survey

Co-Morbid Condition	Mississippi State Consumer Survey n=319		Jackson MSA Consumer Survey n=130	
	#	%	#	%
STIs	38	11.9%	17	13.1%
Hepatitis B or C	18	5.6%	5	3.8%
TB	7	2.2%	2	1.5%
Emotional Stress	116	36.4%	43	33.1%
Other	8	2.5%	4	3.1%

Focus Group Comments

- "Hepatitis C is a big challenge for us and we are finally getting our hands on the medications. It is not covered by ADAP."
- "The prisoners who have Hep C just live with it, and complications are handled as they arise."
- "Gonorrhea, Hep C, Chlamydia; we had to start doing follow-ups on those."
- "I think the increase in HIV is correlated to the increases in syphilis and with HIV you can be more susceptible to getting STDs."
- "Pretty much all ages. I have started to see an increase in young people. A couple of years ago it was kind of unheard of to see a 19-year-old come in with syphilis. Now you're seeing it every day. Male or female, gay or straight. It's out there, just like HIV crossed over the heterosexual population, syphilis is starting to cross over to the heterosexual population."
- "We used to do screening in the high school, but we were no longer doing it until last month. I got two cases out of the high school."
- "There's a lot of people incarcerated and if you're in prison no one talks about what happened so a lot of times you hear, 'My girlfriend gave it to me,' . . . that really didn't happen, it happened in prison but no one talks about it."
- "Jails test prisoners coming in but they refuse to test those coming out . . . they don't care."

Key Informant Comments

- "HIV is now a chronic disease; people are living longer . . . I see it as an issue in this State because we have a shortage of physicians and nurse practitioners who want to deal with HIV, and as we see people grow older with this disease, we are going to see more and more people who emerge with other complications."
- "Pneumonia."
- "We don't have a lot of IV drug use, so Hep C is not a problem of the same magnitude as in other parts of the country. The co-morbidities that affect Mississippians more are diabetes, hypertension and obesity. Our HIV patients are living longer so it's more common for them to develop more of these diseases."
- "We have a significant issue with crack and meth. It's become worse over the last two years. They've gotten better about it. They've started shooting up so we won't see their teeth falling out."

E. DATA: ACCESS, SOURCES AND SYSTEMS

Main Sources of Data

Surveillance data were obtained from the Mississippi State Health Department, Office of STD/HIV where the HIV/AIDS Reporting System (eHARS) is maintained. Data utilized for this needs assessment are through 2014, the most recent year in which data are complete. Data for the HIV Care Continuum (HCC) were also from eHARS. The Part B Program data utilizes CAREWare for data collection and reporting. Program data, including the 2015 RSR, are from this source. HIV testing data are maintained in eHARS. Quality management reporting systems utilize CAREWare data analyzed through Evaluation Web. HOPWA data are maintained jointly by MSDH and Jackson Medical Mall Foundation.

The needs assessment includes an extensive database of consumer characteristics, attitudes and service preferences obtained from a consumer survey undertaken in 2016. Key informant interviews and focus groups were also undertaken in 2016. Data were collected and reported by New Solutions, Inc. Data used in Section C were obtained from MSDH, and are through 2016.

The needs assessment further utilizes numerous prior research studies to support the updated information presented in this report. A list of references is provided at the end of this section.

Data Policies and Limitations

As of February 2013, MSDH requires mandatory reporting of CD4 and viral loads by commercial laboratories in Mississippi. Reports are received electronically as well as on paper to identify individuals living in Mississippi diagnosed with HIV.
Data used to construct the HIV Care Continuum were calculated according to the following definitions.

- Number of persons ever diagnosed with HIV infection through 12/31/2013 and living with HIV on 12/31/2014 reported as of 5/31/2016. The overall population may be overestimated as cases are followed for up to 16 months as opposed to 18 months as recommended by CDC to collect death certificate information.
- Linked to care: Number of persons with one or more CD4, viral load or HIV-1 genotype test between 01/01/2014 through 12/31/2014. Persons were equal to or greater than 13 years of age at diagnosis, resided in Mississippi at diagnosis and diagnosed with HIV infection between 01/01/2014 and 12/31/2014 as reported through 5/31/2016. Linked to care were identified within 30 days, 91 days, 182 days and 365 days of diagnosis.
- Retained in care: Number of persons with two or more CD4, viral load or HIV-1 genotype test at least 91 days apart between 1/01/2014 through 12/31/2014. Persons were equal to or greater than 13 years of age at diagnosis, resided in Mississippi at diagnosis and diagnosed with HIV infection between 01/01/2014 and 12/31/2014 as reported through 5/31/2016.
- As the registry does not maintain data on ARV treatment, the HCC does not display this element.
- Viral suppression: Number of persons with viral load test result <200 copies/Ml BETWEEN 01/01/2014 THROUGH 12/31/2014.

Limitations

MSHD recognizes data limitations of HIV testing, particularly as related to reporting of MSM. In 2014, 35% of PLWH (39% in Jackson MSA) reported unknown or unidentified transmission mode. MSDH has since taken steps to reduce stigma related to sexual encounters and to encourage individuals to acknowledge their sexual preferences. Results have been encouraging. Another limitation includes the lag time in reporting surveillance data.

Presently, Part B and Part A data are separately maintained. Part A providers are funded by the Memphis Transitional Grant Area and serve Mississippi counties of Desoto, Tate, Tunica and Marshall. However, ADAP serves all Mississippi residents and its database does not differentiate from Part A or Part B.

Another data limitation pertains to non-integration of care data, now maintained in CAREWare but not integrated with eHARS. MSDH is receiving technical assistance from the University of Washington's Public Health Capacity Building Center and CDC to create a combined data set of surveillance and care data.

Unavailable Resources

Perhaps the most useful but unavailable resource would be a reliable database of co-morbid conditions that include diagnoses of hepatitis, STI and substance abuse as part of the surveillance registry. Presence of STI is well established as a risk factor for HIV, and quantification at the point of HIV diagnosis would be useful. The other co-morbid conditions would be useful as well to identify emerging conditions, trends, etc.

Although care data provide estimates of ARV therapies, the data are not sufficiently compatible with surveillance data to include in the HCC. Mississippi can and does construct HCC's in different formats for each of its care clinics, and they are useful for quality management purposes. They do not necessarily reflect the overall HCC within specific geographic areas, such as Jackson MSA. Such data would be helpful when identifying specific geographic areas to target for intervention.

Finally, integration of the disparate databases – surveillance, care, HOPWA, ADAP, prevention – would allow for more accurate depth information to be used in a needs assessment. MSDH is already taking steps to merge various data sets; however, the task is considerable and at times daunting.

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APPENDIX A
SUPPLEMENTAL TABLES

Children or Dependents

- A third of consumer survey respondents from Mississippi had children or dependents.
- Nearly 30% of survey respondents from the Jackson MSA had children or dependents.

Table APP-1
Children or Dependents
Mississippi State and Jackson MSA Consumer Survey

Children or Dependents	Mississippi State Consumer Survey n=319		Jackson MSA Consumer Survey n=130	
	#	%	#	%
Yes	105	32.9%	36	27.7%
No	214	67.1%	94	72.3%

- Survey respondents in Mississippi are more likely to live alone (29%) or with one other person (30%).
- Survey respondents in the Jackson MSA were more likely to be living in households of 4 or more, 32%, or to be living alone, 27%.

Table APP-2
How many people live in your household?
Mississippi State and Jackson MSA Consumer Survey

Persons in Household	Mississippi State Consumer Survey n=319		Jackson MSA Consumer Survey n=130	
	#	%	#	%
One	93	29.2%	35	26.9%
Two	94	29.5%	30	23.1%
Three	58	18.2%	23	17.0%
Four or More	74	23.2%	42	32.3%

HIV Diagnosis & Linkage to Care

- The largest group of Mississippi consumer survey respondents were diagnosed with HIV between 2000 and 2010 (35%), followed by those diagnosed between 2010 and 2015 (34%).
- The largest group of survey respondents from the Jackson MSA were diagnosed between 2000 and 2010 (36%), and between 2010 and 2015 (34%).

Table APP-3
When were you diagnosed with HIV?
Mississippi State and Jackson MSA Consumer Survey

Timeframe	Mississippi State Consumer Survey n=319		Jackson MSA Consumer Survey n=130	
	#	%	#	%
Within the last year	14	4.4%	3	2.3%
2010 – 2015	107	33.5%	44	33.8%
2000 – 2010	110	34.5%	47	36.2%
1990 – 1999	60	18.8%	30	23.1%
Before 1990	13	4.1%	3	2.3%
Don't know / Don't remember	15	4.7%	3	2.3%

APPENDIX B
MISSISSIPPI STATE DEPARTMENT OF HEALTH
HIV NEEDS ASSESSMENT
KEY INFORMANT INTERVIEW GUIDE

Name_____ Title_____

Affiliation_____ Date_____

County/Region_____

PREVENTION

1. How would you describe HIV prevention in the state of Mississippi or your specific jurisdiction? PROBE: How available or accessible are services? How appropriate are services to specific at risk populations? Are services sufficient in magnitude? How would you rate the quality of prevention services?

2. What are the strengths and weaknesses of the HIV Care Continuum?

3. How would you describe the prevailing public attitudes concerning HIV prevention steps such as counseling, consistent condom use, etc.?

4. A) What challenges exist to educate those at high risk for HIV infection, or other priority populations, about preventing HIV infection and getting HIV testing? B) What systemic issues impede the progress of education those at high risk for HIV and preventing new infection? C) Which of these issues you mentioned are within control of the HIV service delivery system?

5. What barriers exist in the acceptance or use of PrEP? Do you counsel patients about PrEP?

6. How effectively do HIV stakeholder groups work in collaboration with each other? Discuss (1) efforts to improve community awareness, outreach, testing, and community involvement; and (2) coordination of testing, linkage, engagement and retention in care.

TESTING

1. Please describe the process your clients typically experience when getting tested for HIV. Where in this process do breakdowns most often occur in terms of patients failing to proceed to the next step? (Probe: access, timeliness, insurance, stigma…)
2. How would you describe the prevailing public attitudes concerning HIV testing? What are the challenges to prompting or motivating people to get tested? Are there any barriers to HIV testing? What are the opportunities to improve testing?

3. Which of these issues you mentioned are within control of the community-based organizations? The health care providers? Government agencies? Other systems?

4. How effectively do HIV stakeholder groups/organizations collaborate with each other to increase HIV testing? Discuss (1) efforts to improve community awareness, outreach, testing, and community involvement; and (2) coordination of testing, linkage, engagement and retention in care.

TREATMENT

1. Please assess the present state of HIV health (including mental, dental, and vision) care available to your patients. Where do you see the future of HIV care? Discuss emerging health issues including co-morbidities and the extent to which they complicate HIV care. What co-morbidities pose the most serious concern for treatment providers?

2. What do you think are the main reasons PLWH drop out of HIV care? (Probe for systemic issues)

3. Please discuss the current barriers or needs of HIV patients in terms of obtaining and staying in care. How do these impact priority populations specifically? What gaps in the continuum of care and treatment or in essential services exist that result in barriers to retaining PLWH in care?

4. Which of these issues you mentioned are within control of the system of care and what can be done to improve linkage, engagement and retention?

5. How effectively do HIV care providers collaborate with each other? Discuss coordination of services as they relate to engagement and retention in care.

6. Do you have suggestions for (a) improving the system or processes the client undergoes to achieve rapid linkage to care (b) re-engagement to care for those out of care? (c) retention in care? (d) medication adherence and viral load suppression?

APPENDIX C
MISSISSIPPI STATE DEPARTMENT OF HEALTH
HIV NEEDS ASSESSMENT
FOCUS GROUP GUIDE

TESTING, PREVENTION AND EARLY INTERVENTION

1. What can be done to enhance efforts to link patients to care once they have tested positive?
    - Are different approaches used for:
        - Young MSM
        - African-American Men
        - African-American Women
        - Whites
        - Hispanics
        - Transgender

2. Are there any specific barriers that young people in linking to care?
   PROBE:
    - Parental consents for treatment
    - Closeted young people who are on their parent's insurance

3. We have seen increases in the number of new clients in each HSDA – To what do you attribute this? Who are these clients?

4. We have seen increases in Syphilis. To what do you attribute this? Who are these clients?

5. What are emerging needs for HIV prevention services in the HSDA?
   PROBE:
    - PrEP, outreach, peer supports

6. What existing prevention and/or early intervention services need improvements?
   PROBE:
    - Partner elicitation and notification
    - Patient navigation from testing to linkage sites

7. Are prevention workers using social media to get the word out to high-risk patients?

BARRIERS AND ACCESS

8. What issues or barriers do prevention/testing agencies experience in getting newly identified linked to care?
    - Patients tested after hours – how long does it take to link these patients to care versus those who are tested during business hours?
    - How or what would you consider successful linkage?

9. Please identify barriers that impede PLWH from linking in care and remaining in care?
PROBE:
    - PLWH who know their status but are not in care
    - Certain populations or underserved groups
    - Coordination among HIV prevention, care and treatment that slows access to services
    - How well does the relationship between prevention and treatment services work

10. Let's discuss barriers to HIV prevention and care services.
PROBE:
    - Structural barriers (poverty, culture, stigma)
    - Federal, State or local legislative policy barriers (insurance coverage, policies on testing or reporting, other agency policies or procedures) that are burdensome.
    - Client access barriers (transportation, homelessness/housing, inability to navigate the system, poverty, co-morbid conditions).
    - Infrastructure barriers such as capacity, access to data, data sharing, adequacy of health information systems, funding.

11. Let's discuss agency capacity.
PROBE:
    - What is the capacity of the agency to get a new patient into care and retain them in care?
    - What is the agency capacity to keep clients actively engaged, suppressing their viral loads and getting them to return?
    - What is the agency's capacity to get those lost to care to return?

12. How well do agency requirements (for new, established or returning to care consumers) fit the capacity of the client?

COLLABORATION

13. Let's discuss the contributions of stakeholders and key partners.
PROBE:
    - How can the Planning Council improve its effectiveness in addressing barriers?
    - Are there stakeholders not involved that need to be involved?
    - What could be done to improve coordination?

14. What suggestions do you have to improve the system in your District/Region?

APPENDIX D
MISSISSIPPI STATE HEALTH DEPARTMENT
2016 HIV CONSUMER SURVEY
(English Version)

Agency: _____ **Date: _____**

Contact Person: _____

Thank you for helping the Mississippi State Health Department with this 2016 survey. We want to know about your needs and how to best help you stay in medical care. Your honest participation will help improve services for you and others. Your answers will remain *confidential*, and you will *not* be identified. If you complete the survey, you will receive a special gift card for helping us better serve your needs.

Circle your correct answer. Please answer EVERY question.

1. Are you currently HIV positive?
a. Yes
b. No **{(If No, STOP. Do not complete the survey.)}**

2. Have you completed this survey in the past month?
a. Yes **{(If Yes, STOP. Do not complete the survey.)}**
b. No

3. Where are you taking the survey?
a. GA Charmichael Family Health Center
b. Crossroads North
c. Aaron E. Henry Community Health Center
d. Southeast Mississippi Rural Health Initiative - Hattiesburg Family Health Center
e. My Brother's Keeper LGBT Wellness Center
d. AIDS Services Central
e. Crossroads Central
f. Grace House
g. Jackson Medical Mall Foundation – Care
h. Open Arms Healthcare Center
i. Southern Health Commission
j. Over the phone
k. On my personal device
l. ADAP
m. Coastal Family Health Center
n. UMMC – Adult Special Care
o. Sacred Heart Southern Missions

4. What is your gender now?
a. Male
b. Female
c. Transgender Female to Male
d. Transgender Male to Female

5. What is your race?

a. Black, African American
b. Asian or Pacific Islander
c. American Indian or Alaska Native
d. White
e. Other race
f. More than one race

6. Are you Hispanic or Latino?

a. Yes
b. No

7. When were you born? (month/day/year) __ __ / __ __ / __ __ __ __

8. Where do you live?

a. City of Jackson (includes metro area)
b. Other Mississippi County
c. Other State (specify) _____
d. Other (specify) _____

9. What is the ZIP code where you live? _____

10. In what country were you born?

a. United States of America
b. Other (specify) _____

11. What language do you speak most of the time in your home?

a. English
b. Spanish
c. Other (specify) _____

12. How would you describe your current housing situation?

a. I rent or own my house or apartment/condo (non-subsidized).
b. I rent or own my house or apartment/condo with subsidized assistance, for example: I have Section 8.
c. I live in group or congregate housing for people living with HIV/AIDS.
d. I am staying with family or friends.
e. I am in temporary housing, a treatment facility or a halfway house.
f. I am in a shelter.
g. I am in adult foster care or hospice.
h. I am in the street. I have no home.

13. Do you have children or dependents?

a. Yes
b. No

14. How many persons live in your household?

a. One
b. Two
c. Three
d. Four or more

15. What is your current gross (before taxes) annual household income for you and any dependents in your household that you state on your tax return?

a. $0 No income
b. $1 to $11,999
c. $12,000 to $23,999
d. $24,000 to $49,999
e. $50,000 or more
f. Decline to answer

16. Are you employed?

a. Yes, full-time
b. Yes, part time
c. Occasionally
d. No but looking for work
e. No, not looking for work
f. Decline to answer

17. What type of insurance do you have? Check all that apply.

a. Medicaid **{SKIP to Question 19}**
b. Medicare **{SKIP to Question 19}**
c. Private **{Go to Question 18}**
d. None **{SKIP to Question 19}**

18. If you have private insurance, did you get it through

a. Your employer
b. The marketplace exchange (i.e. Affordable Care Act / Obama Care)
c. Other (specify) _____

19. What is the highest level of education you completed?

a. 8th grade or less
b. Some high school
c. High school graduate/GED
d. Technical or trade school/VOTECH
e. Some college/community college graduate
f. College graduate
g. Post-Graduate

20. Have you been in jail/detention center or prison in the last 12 months?

a. Yes
b. No
c. Decline to answer

21. Do you think of yourself as …(Choose one)

a. Straight/Heterosexual
b. Homosexual Male/Gay
c. Homosexual Female/Lesbian
d. Bisexual
e. Questioning

22. How do you think you were infected with HIV? (Circle one)

a. I had sex with a man
b. I had sex with a woman
c. I had sex with both a man and a woman
d. I shared needles or works
e. I received blood products/transfusion
f. I was born with it
g. I don't know

23. What year did you first test positive for HIV?

a. Before 1990
b. 1990 - 1999
c. 2000 - 2009
d. 2010 - 2015
e. Within the last year – 2016
f. Don’t know/ don’t remember

24. In the last 12 months, did you get any Ryan White or ADAP services?

a. Yes
b. No
c. Don't know/don't remember

25. In the last 12 months, did you get HOPWA?

a. Yes
b. No
c. Don't know/don't remember

26. After receiving your HIV diagnosis, how soon did you have your first visit with a HIV medical care provider?

a. The next day
b. Within 1 - 3 months after diagnosis
c. Within 4 -6 months after diagnosis
d. Within 7 – 12 months after diagnosis
e. One year or more after diagnosis
f. I haven't seen a doctor or health professional for HIV

27. In the last 12 months, have you (Circle one for each question.)

a. Received lab tests for CD4 count or viral load?	**Yes**	**No**	**I don't know**
b. Taken HIV medication (antiretroviral)?	**Yes**	**No**	**I don't know**
c. Been to a HIV medical provider to get HIV medical care?	**Yes**	**No**	**I don't know**

{If "NO" or "I DON'T KNOW" to a, b and c, ANSWER Question 28. If "YES" to a, b or c, GO TO Question 29.

28. Why didn't you get medical care within twelve months of your diagnosis? {(Circle all that apply go to the next question.)}

a. Can't afford care
b. Insured but the cost of care or meds is too high
c. Inconvenient clinic hours or location.
d. No reliable transportation.
e. Wait for appointment is too long or I'm unable to get an appointment.
f. Forgot appointments.
g. I was not sick so I did not think I needed medical care.
h. Other day to day responsibilities are more important (child care; work).
i. Lack of stable housing/homelessness.
j. Incarcerated/in jail.
k. Don't want to think about being HIV positive.
l. I felt good/no need for care or treatment.
m. I felt too sick to go.
n. I did not know where to go for medical care/can't find a provider.
o. I don't like/trust my doctor.
p. Using alcohol or drugs or relapsed (started using street drugs/alcohol).
q. Too depressed/other mental problems.
r. I was worried someone might find out I am HIV positive.
s. Using alternative therapies (herbs, vitamins, acupuncture, massage therapy)
t. I didn't find a doctor or nurse that I wanted to treat me.
u. Not really sure I'm HIV positive.
v. Faith in God - don't need medical care.
w. Other reason (specify) _____

29. Do any of the following make it hard for you to stay in HIV medical care or cause you to miss HIV medical care appointments? {(Circle all that apply and go to the next question.)}

a. Wait for appointment is too long or appointment times are inconvenient.
b. I am worried someone might find out I am HIV positive.
c. Trouble getting reliable transportation.
d. Lack of child care.
e. Sometimes feel too sick to go.
f. I don't like/trust my doctor.
g. Using street drugs or alcohol.
h. Too depressed/other mental problems.
i. Different doctor or health professional each visit.
j. Staff does not speak my language.
k. Insured but the out of pocket cost of care or meds is too high.
l. I don't understand why I need treatment or my treatment options.
m. Other reason(s):

30. In the past 12 months, have you had any of the following conditions or infections listed below: (Circle all that apply.)

a. STIs (such as Syphilis, Gonorrhea, Chlamydia, etc.)
b. Hepatitis B or C
c. TB (tuberculosis)
d. Emotional stress (such as depression, anxiety)
e. Other (specify) _____

31. In the past twelve months, did you use any of the following substances? {(Circle all that apply and go to the next question.)}

a. Alcohol, more than 15 drinks per week
b. Tobacco, everyday or most days
c. Cocaine/Crack
d. Heroin/Other Opiates
e. Methamphetamines/Other Stimulants
f. Marijuana
g. Club Drugs (X, G, Special K, etc.)
h. LSD/Acid/Other Hallucinogens
i. Hormones or steroids
j. Prescription drugs such as Oxycodone, Vicodin, Percocet
k. Other (specify) _____

32. In the past 12 months, have you had receptive anal, vaginal or oral sex (i.e. someone inserted his penis into your body)?

a. Yes
b. No
c. Don't remember
d. None of the above; have not had sex

{If yes, answer Question 33. If no, SKIP to Question 37.}

33. When you have receptive or insertive sex, how many times out of ten would you use a condom or latex barrier?

a. 0
b. 1
c. 2-5
d. 6-9
e. 10

{If you answered a-d, answer Question 34. If you answered e, SKIP to Question 36.}

34. Why don't you use protection all the time when having sex? {(Circle all that apply and go to the next question.)}

a. I love and trust my partner.
b. I don't like using protection.
c. Protection interferes with sexual activity.
d. Problem with erection (erectile dysfunction)
e. I want to have a baby.
f. Protection is not always available.
g. My partner does not like using protection.
h. I am sometimes high or buzzed on drugs or alcohol during sex.
i. It's not really sex with protection.
j. I don't care about protection.
k. Other (specify) _____

35. Have you ever used any of these prevention services? {(Circle all that apply and go to the next question.)}

a. Free condoms
b. Syringe exchange
c. HIV Hotlines for information
d. Safer sex workshops
e. Behavioral intervention classes, such as CLEAR, ARTAS, RESPECT, 3MV, VOCES
f. Other prevention services (specify) _____
g. I don’t use prevention services.

36. Has your partner taken medication to avoid HIV?

a. Yes
b. No
c. I don’t know

37. Do you get or do you need any of these services? (Check all that apply and go to the next question.)

	I get it	I don't get it and I need it	I need it but I don't know how to get it	I don't need it
a. Help paying for your HIV medications				
b. Dental care				
c. Help getting other medical care after diagnosis				
d. Help paying for insurance, co-pays or deductibles				
e. Health care services at home				
f. Mental health services				
g. Nutritional counseling				
h. Food bank				
i. Meals delivered to your home				
j. Outpatient substance abuse treatment/detox				
k. Residential substance abuse treatment				
l. Emergency housing/shelter				
m. Education to help you follow your HIV medical treatment				
n. Case management				
o. Child care services				
p. Emergency financial assistance for utilities, food, medications				
q. Help with paying your rent or mortgage				
r. Help paying for housing in an emergency				
s. Education about HIV and how to reduce risk				
t. Legal services				
u. Translation services				
v. Transportation to medical care				
w. Transportation to substance abuse treatment				
x. Rehabilitation services (PT, OT or speech)				
y. Medical day care for adults				

38. Other comments or suggestions?

Please hand in your survey to the site administrator to receive your WalMart gift card.

Thank you.

APPENDIX E
DEPARTAMENTO DE SALUD DEL ESTADO DE MISSISSIPPI
2016 ENCUESTA DE CONSUMIDORES VIH
(Spanish Version)

Agencia: _____ **Fecha: _____**

Persona de Contacto: _____

Gracias por ayudar al Departamento de Salud del Estado de Mississippi con esta encuesta de 2016. Queremos saber acerca de sus necesidades y cómo ayudarle en la mejor manera, mantenerse en la atención médica. Su participación honesta ayudará a mejorar los servicios para Usted y otros. Sus respuestas serán *confidenciales* y *no* serán identificadas. Si completa la encuesta de una sentada, recibirá una tarjeta de regalo especial por su ayuda.

Encierre en un círculo la respuesta correcta. Por favor, conteste TODAS las preguntas.

1. ¿Es Usted VIH positivo?
a. Sí
b. No **{(Si su respuesta es No, no complete el cuestionario)}**

2. ¿Ha completado esta encuesta en el último mes?
a. Sí **{(Si respondio "Sí," no continúe.)}**
b. No

3. ¿Dónde está tomando la encuesta?
a. GA Charmichael Family Health Center
b. Crossroads North
c. Aaron E. Henry Community Health Center
d. Southeast Mississippi Rural Health Initiative - Hattiesburg Family Health Center
e. My Brother's Keeper LGBT Wellness Center
d. AIDS Services Central
e. Crossroads Central
f. Grace House
g. Jackson Medical Mall Foundation – Care
h. Open Arms Healthcare Center
i. Southern Health Commission
j. Over the phone
k. On my personal device
l. ADAP
m. Coastal Family Health Center
n. UMMC – Adult Special Care
o. Sacred Heart Southern Missions

4. ¿Cuál es su género ahora?
a. Masculino
b. Femenino
c. Transgénero Femenino a Masculino
d. Transgénero Masculino a Femenino

5. ¿Cuál es su raza?

a. Negra, Africana Americana
b. Asiático o Islas del Pacífico
c. Indio Americano o Nativo de Alaska
d. Blanca
e. Otra raza
f. Más de una raza

6. ¿Es Usted Hispano o Latino?

a. Sí
b. No

7. ¿Qué es su fecha de nacimiento? (mes/día/año) __ __ / __ __ / __ __ __ __

8. ¿Dónde vive Usted?

a. Ciudad de Jackson (incluye área metropolitana)
b. Otro condado de Mississippi
c. Otro Estado (especifique)_____
d. Otro (especifique)_____

9. ¿Qué es el código postal donde Usted vive? _____

10. ¿En que país nació Usted?

a. Estados Unidos de América
b. Otro (especifique) _____

11. ¿Qué idioma habla Usted la mayoría del tiempo en su casa?

a. Inglés
b. Español
c. Otro (especifique) _____

12. ¿Cómo Usted describíria su situación de vivienda ahora?

a. Renta o es dueño de casa o apartamento/condominio (sin subsidio)
b. Renta o es dueño de su apartamento/condominio, con subsidio. Por ejemplo: Tiene Sección 8
c. Vivienda de grupo o compartida para personas viviendo con VIH/SIDA
d. Quedándose con familia o amistades
e. Vivienda temporal, institución de tratamiento o casa de medio camino
f. Estoy en un albergue
g. Acogimiento de adultos o hospicio
h. Estoy en la calle. No tengo vivienda.

13. ¿Tiene hijos o dependientes?

a. Sí b. No

14. ¿Cuántas personas viven en su casa?

a. Una
b. Dos
c. Tres
d. Cuatro o más

15. ¿Cuál es su ingreso bruto actual (antes de impuestos) annual, para Usted y los dependientes de su hogar que estan incluidos en su declaración de impuestos?

a. $0 sin ingresos
b. $1 a $11,999
c. $12,000 a $23,999
d. $24,000 a $49,999
e. $50,000 o más
f. Prefiero no contestar

16. ¿Está Usted empleado?

a. Sí, tiempo completo
b. Sí, medio tiempo
c. Ocasionalmente
d. No, pero estoy en busca de trabajo
e. No, no estoy en busca de trabajo
f. Prefiero no contestar

17. ¿Qué tipo de seguro tiene? Marque todo lo que corresponde.

a. Medicaid **{**proceder a la pregunta 19**}**
b. Medicare **{**proceder a la pregunta 19**}**
c. Privado **{** proceder a la pregunta 18**}**
d. Ninguno **{**proceder a la pregunta 19**}**

18. ¿Si Usted tiene seguro privado, lo consiguió a través de?

a. Su empleador
b. Sobre la Ley de Cuidado de Salud a Bajo Precio
c. Otro (especifique) _____

19. ¿Cual es el nivel mas alto de educación que Usted completó?

a. Grado 8 o menos
b. Algo de bachillerato
c. Graduado de la escuela secundaria/GED
d. Escuela técnica o de comercio/ VOTECH
e. Algo de universidad
f. Graduado de universidad
g. Nivel de postgrado

20. ¿A estado en la cárcel o prisión en los últimos 12 meses?

a. Sí b. No c. Prefiero no contestar

21. ¿Cuál describe como Usted se identifica? (escoja uno)

a. Convencional/Heterosexual
b. Hombre homosexual/Gay
c. Mujer homosexual/Lesbiana
d. Bisexual
e. Cuestionando

22. ¿Cómo cree Usted que fue infectado con VIH? (elija uno)

a. Tuve relaciones sexuales con un hombre
b. Tuve relaciones sexuales con una mujer
c. Tuve relaciones sexuales con un hombre y una mujer
d. Compartí agujas/equipo
e. A través de productos de sangre/transfusión
f. Yo nací con VIH
g. No sé

23. ¿En que año resulto VIH positivo por primera vez?

a. Antes de 1990
b. 1990 - 1999
c. 2000 - 2009
d. 2010 - 2015
e. En este último año – 2016
f. No sé/no recuerdo

24. ¿En los últimos 12 meses, a recibido servicios de Ryan White o ADAP? *(ADAP es un Programa de Asistencia de Medicamentos para el SIDA)*

a. Sí
b. No
c. No sé/no recuerdo

25. ¿En los últimos 12 meses, a recibido HOPWA? *(HOPWA es Oportunidades de Vivienda para Personas con SIDA)*

a. Sí
b. No
c. No sé/no recuerdo

26. ¿Después de recibir su diagnóstico de VIH, cuando fue su primera visita a un proveedor de atención médica del VIH?

a. Al día siguiente
b. Entre 1 – 3 meses después del diagnóstico
c. Entre 4 - 6 meses después del diagnóstico
d. Entre 7 – 12 meses después del diagnóstico
e. Un año o mas después del diagnóstico
f. No ha consultado con un doctor o profesional de salud para el VIH

27. ¿En los últimos 12 meses, a Usted (conteste cada pregunta)

a. Recibido pruebas de laboratorio para recuento de células CD4 o carga viral?	**Sí**	**No**	**No sé**
b. Tomado medicamentos de VIH (antirretrovirales)?	**Sí**	**No**	**No sé**
c. Ido a un proveedor de servicios médicos de VIH para recibir atención médica del VIH?	**Sí**	**No**	**No sé**

{Si su respuesta fue “no” o “no sé” a las preguntas a, b y c, conteste la pregunta numero 28. Si su respuesta fue “si” a las preguntas a,b o c, conteste la pregunta numero 29.}

28. ¿Porque no obtuvo cuido médico dentro los primero 12 meses de su diagnóstico? {(Marque todas las opciones que corresponden)}

a. No puedo pagar la atención medica
b. Tengo seguro, pero el costo de atención medica o medicamentos es alto
c. Horario o ubicación de la clínica es inconveniente
d. No hay transporte confiable
e. La espera para una cita es demasiado tiempo o no puede conseguir una cita
f. Olvide las citas
g. No estaba enfermo, así que no pensé que necesitaba atención médica
h. Otras responsabilidades diarias más importante (cuidado de niños, el trabajo)
i. Falta de vivienda estable o sin hogar
j. Estaba en la cárcel
k. No quiero pensar en ser VIH positivo
l. No me sentía enfermo, así que no necesitaba atención médica
m. Me sentía demasiado enfermo para ir
n. No sabía a dónde ir para el cuido médico
o. No me gusta / no confio en mi médico
p. Estaba usando drogas o volví al vicio (comencé a usar drogas/alcohol)
q. Demasiado deprimido / otros problemas mentales
r. Estaba preocupado de que alguien se entere de que soy VIH positivo
s. Usé terapia alternativa (hierbas, vitaminas, acupuntura, terapia de masaje)
t. No encontré un médico o un enfermero que quería tratarme
u. No estoy seguro que soy VIH positivo.
v. Fe en Dios- no necesito atención médica
w. Otro (especifique)_____

29. ¿Algunos de lo siguiente le causa dificultad para obtener atención médica de VIH o le causa que falte citas de atención médica de VIH? {(Marque todas las opciones que corresponden**)}**

a. La espera para una cita es demasiado tiempo o las horas son inconvenientes
b. Me preocupa que otros se enteren que soy VIH positivo
c. Problemas en conseguir transporte confiable.
d. No tenia a nadie que me cuide a mis hijos
e. Me sentía demasiado enfermo para ir
f. No me gusta / no confio en mi médico
g. Estoy usando drogas o alcohol
h. Demasiado deprimido / otros problemas mentales
i. En cada visita es un médico o profesional de salud diferente
j. Los empleados no hablan mi idioma
k. Tendo seguro, pero el costo fuera de bolsillo para atencion medica o medicinas es demasiado alto
l. No entiendo porque necesito tratamiento ni mis opciones de tratamiento
m. Otras razones:

30. ¿En los últimos 12 meses, lo han diagnosticado por alguna condición o infección, de la lista siguiente? {(Marque todas las opciones que corresponden)}

a. Infecciones transmitidas sexualmente (por ejemplo, Sífilis, Gonorrea, Clamidia, etc.)
c. Hepatitis B o C
d. TB (tuberculosis)
e. Estrés emocional (como depresión, ansiedad)
h. Otro (especifique)_____

31. ¿En los últimos 12 meses, ha usado alguna de las siguientes sustancias? {(Marque todas las opciones que corresponden)}

a. Alcohol, más de 15 bebidas semanalmente
b. Tabaco, fuma cigarrillos todos los días o algunos dias
c. Cocaína/Crack
d. Heroína/Otros Opiáceos
e. Metanfetaminas/Otros Estimulantes
f. Marihuana
g. Drogas de club (X, G, Special K, etc.)
h. LSD/Acido/Otros Alucinógenos
i. Hormonas o Esteroides
j. Prescription drugs such as Oxycodone, Vicodin, Percocet
j. Otro (especifique) _____

32. ¿En los últimos 12 meses, ha tenido sexo anal receptivo, sexo vaginal o sexo oral (Si alguien introdujo su pene en su cuerpo)?

a. Sí
b. No
c. No recuerdo
d. Ninguna de las anteriores; No he tenido sexo

{Si su respuesta fue "sí", conteste la pregunta numero 33. Si su respuesta fue "no" conteste la pregunta numero 37.}

33. ¿Cuando Usted tiene sexo receptivo o insertivo, cuantas veces de cada 10, usa un condón o un protector de látex?

a. 0
b. 1
c. 2-5
d. 5-9
e. 10

{Si su respuesta fue "a-d", conteste la pregunta numero 34. Si su respuesta fue "e", conteste la pregunta numero 36.}

34. ¿Porqué Usted no usa protección todas las veces cuando tiene relaciones sexuales? {(Marque todas las opciones que corresponden)}

a. Amo y confío en mi pareja
b. No me gusta usar protección
c. La protección interfiere con la actividad sexual
d. Problemas con la erección (Disfunción eréctil)
e. Quiero tener un bebé
f. No siempre hay protección disponible
g. A mi compañero no le gusta usar protección
h. A veces estoy bajo la influencia de las drogas o alcohol durante sexo
i. No es sexo verdadero con protección
j. No me importa la protección
k. Otro (especifique) _____

35. ¿Alguna vez ha utilizado estos servicios de prevención? {(Marque todas las opciones que corresponden)}

a. Condones gratis
b. Intercambio de jeringuillas
c. Lineas telefonicas para informacion sobre el VIH
d. Seminarios acerca de sexo con prevención
e. Clases de intervención de comportamiento, como CLEAR, ARTAS, RESPECT, 3MV, VOCES
f. Otros servicios de prevención (especifique)_____
g. No uso servicios de prevención

36. ¿Su pareja ha tomado medicamentos para evitar el VIH?

a. Sí
b. No
c. No sé

37. ¿Ha obtenido o necesita alguno de estos servicios? (Marque todas las opciones que corresponden.)

	Lo recibo	No lo recibo y lo necesito	Lo necesito , pero no sé cómo conseguirlo	No lo necesito
a. Ayuda para pagar medicinas y recetas				
b. Consultas dentales				
c. Ayuda para recibir otros cuidados médicos después del diagnóstico				
d. Ayuda para co-pagos y deducibles de su seguro				
e. Ayuda de salud domiciliaria				
f. Servicios de salud mental				
g. Servicios de nutrición médica				
h. Banco de Alimentos				
i. Comidas entregadas en su hogar				
j. Programa ambulatorio de tratamiento por abuso de sustancias / desintoxicación				
k. Servicios de abuso de sustancias - Residenciales				
l. Emergencia de vivienda / refugio				
m. Ayuda para entender sus medicamentos y tratamiento				
n. Manejo de casos				
o. Cuido de niños				
p. Asistencia Financiera de Emergencia para utilidades, comida, medicinas				
q. Asistencia de emergencia para renta o hipoteca				
r. Ayuda para pagar la vivienda en caso de emergencia				
s. Educación acerca de VIH y como reducir los riesgos – informacion para prevenir el VIH				
t. Servicios legales				
u. Traducción o Interpretación				
v. Transporte a cuidado médico				
w. Transporte a tratamiento por abuso de sustancias				
x. Servicios de Rehabilitación (terapia física, ocupacional o del habla)				
y. Relevo para adultos				

38. ¿Otros comentarios o sugerencias?

Por favor entregar su encuesta al administrador del sitio para recibir su tarjeta de regalo de WalMart.

Gracias.