HIV/AIDS in the U.S. Deep South:
Trends from 2008-2016

June 2019

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With support from:

Abstract:

Background: HIV surveillance data have identified the South, particularly the Deep South,[1] as having disproportionately high HIV diagnoses and death rates in comparison to other U.S. regions. This report updates a previous report from the Southern HIV/AIDS Strategy Initiative (SASI) that documented HIV/STI epidemiology from 2008-2013 by examining additional years of epidemiologic data (2014-2016). This report also describes federal funding for HIV prevention and care and utilization of Pre-exposure Prophylaxis (PrEP) in the Deep South and other U.S. regions.

Results:

- The Deep South had the highest HIV diagnosis rates and number of individuals diagnosed with HIV of any U.S. region (2008-2016).
- The proportion of individuals diagnosed with HIV who were black men who have sex with men (MSM) increased from 2008-2016 in the Deep South and nationally.
- The Deep South had the highest AIDS diagnosis rates and number of individuals diagnosed with AIDS of any U.S. region (2008-2016)
- Death rates where HIV was the underlying cause of death were highest in the Deep South (2008-2016).
- In the Deep South, 29,799 individuals died where HIV was the underlying cause of death (2008-2016).
- PrEP use per 100,000 population was lowest in the Deep South (2016).
- The Deep South received $200 less in federal funding for HIV prevention/care per person living with HIV than the U.S. average (2016).

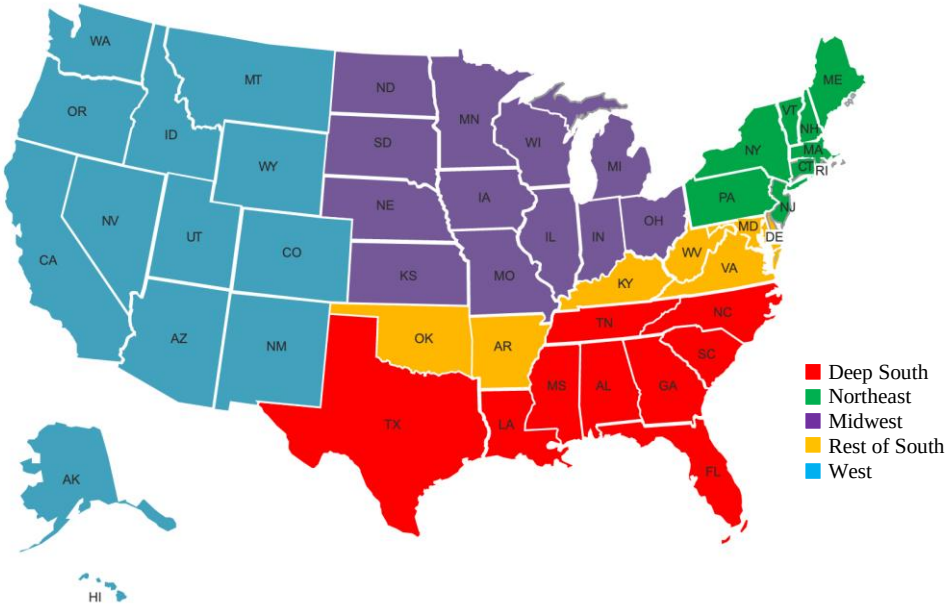
Conclusions: Epidemiologic data regarding HIV diagnoses and mortality indicate that the Deep South has been consistently and disproportionately affected by HIV since at least 2008. In addition, data regarding federal funding for HIV prevention or care (not including Medicaid and Medicare) indicate that the Deep South received less funding per person living with HIV than the U.S average. Although recognition of the disproportionate effects of HIV in the South has increased in the media and at a federal level, including in the updated national HIV/AIDS strategy, and private funding to address HIV in the region has also increased over time, continued focus on effective strategies for addressing and attenuating HIV transmission in the Deep South are needed, if the goal of getting to zero HIV transmissions is to be achieved.

[1] Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee and Texas

BACKGROUND

HIV surveillance data from the Centers for Disease Control and Prevention (CDC) indicate a disproportionate impact of HIV in the Southern U.S.[2] In 2016, the South had the highest HIV diagnosis rate of any U.S. region.[1] Just over half (51%) of HIV diagnoses reported (which includes any new HIV diagnoses regardless of stage of HIV disease) in 2016 were located in the Southern U.S., while this region accounted for only 36% of the U.S. population.[1,2] In addition, the Southern U.S. had the highest death rates among those diagnosed with HIV of any of the four U.S. Census regions (2015).

A subset of Southern states have been particularly affected by HIV disease and share characteristics such as overall poorer health, high poverty rates, an insufficient supply of medical care providers and a cultural climate that likely contributes to the spread of HIV.[3-5] These states include Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Texas, henceforth referred to as the "Deep South." The Deep South states also share similarities in HIV-related outcomes including some of the highest death rates among individuals diagnosed with HIV in the U.S.[3] Longitudinal data from the CDC have been consistent in revealing a greater concentration of HIV diagnoses in the Deep South than in other regions. A Southern HIV/AIDS Strategy Initiative (SASI) report from 2016 provided results from a longitudinal analysis of CDC HIV epidemiologic data from 2008-2013.[6] These findings indicated that the Deep South region had the highest HIV diagnosis rates and highest HIV death rates among individuals diagnosed with HIV from 2008-2013. Despite these concerning statistics, the Deep South has historically lagged behind other regions in CDC and private funding for HIV prevention and care.[7,8]



[2] The U.S. Census Bureau defines the South as including Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, Oklahoma, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia

The dire need to address HIV in the South/Deep South has been increasingly recognized at federal and private funder levels, as evidenced by the South being designated as a focus area in the National HIV/AIDS Strategy and the recent allocation of significant private resources to address HIV in the South through the Gilead Sciences Foundation[9] and ViiV Healthcare.[10] In order to adequately target funding and create programs, it is critical to document the current epidemiology of HIV in the US. This manuscript updates a previous longitudinal analysis of HIV epidemiologic data by including CDC HIV surveillance data from 2014, 2015, and 2016. In addition, the report analyzes HIV mortality using ICD-10 codes to examine death rates with HIV as an underlying cause and compares these rates by state and U.S. region. The report also updates information about funding for HIV by region and explores related issues such as STI prevalence and dissemination of pre-exposure prophylaxis (PrEP).

METHODS

Data for this report were downloaded from the CDC's HIV Surveillance System Database, Atlas, for the years 2008 through 2016—2008 was the earliest year of all 50 states reporting with standard definitions of people diagnosed with HIV and AIDS at the time of this report.[1] The Atlas data are statistically adjusted by the CDC for missing data (such as reporting delays) but not for incomplete reporting (such as anonymous testing). The data are also unduplicated for individuals on a national level. With these caveats, the Atlas numbers are estimated to be 80% complete and are currently the best source for trends in HIV diagnoses, prevalence, and deaths.[11]

We report rates for HIV and AIDS diagnoses, prevalence, deaths, case fatality, and STDs for the years 2008-2016, providing a comparative regional assessment of trends in HIV disease in the U.S. with a focus on the Deep South states. U.S. regions were defined using the U.S. Census Bureau's segmentation of the country into South, Northeast, Midwest, and West.[12] The South was broken into two groups: the Deep South (Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas) and the rest of the South (Maryland, Delaware, DC, Virginia, West Virginia, Arkansas, Kentucky, Oklahoma).

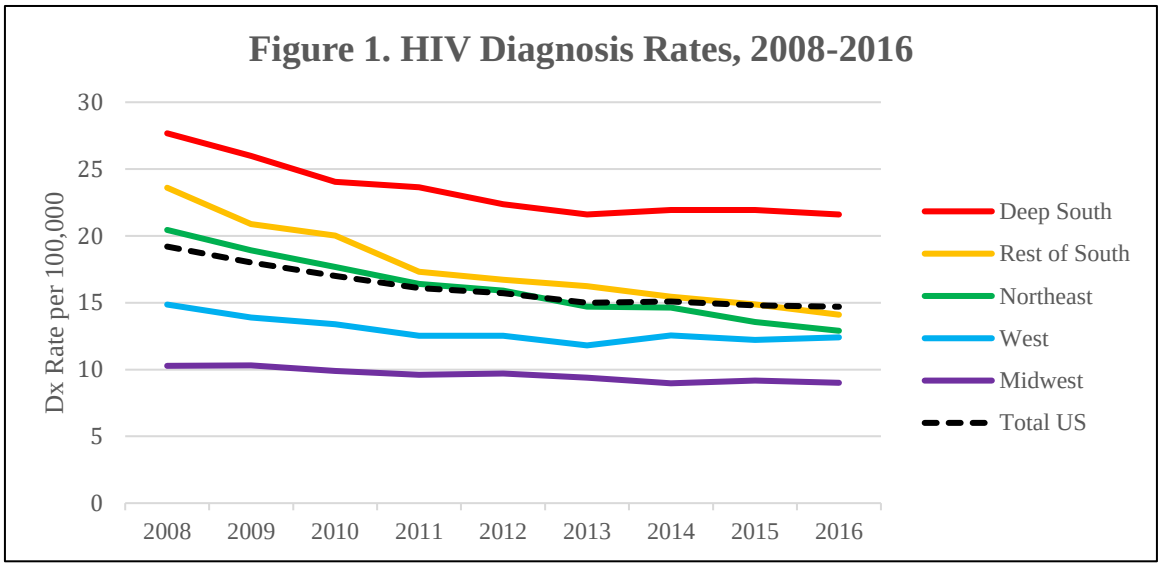
The HIV and AIDS diagnosis and prevalence rates and the death rates were calculated by dividing the total number of cases in the region by the total population within the region divided by 100,000. HIV death rates among individuals diagnosed with HIV were calculated as the number of HIV deaths divided by the number of people living with HIV (prevalence) and reported as the percentage of all people with HIV that died during that year. AIDS death rates among individuals diagnosed with AIDS were calculated using a similar method. In addition, the CDC releases HIV death data for ICD-10 codes related to HIV in their CDC Wonder database and calculates age adjusted death rates per 100,000 population for each state and for the four Census regions.[13] The CDC Wonder data from each state were used to calculate the HIV death rate where HIV was the underlying cause of death in the Deep South region for 2008-2016.

Data on Pre-exposure Prophylaxis utilization from 2012-2016 for each state was obtained from AIDSVu.[14] AIDSVu is an interactive online tool for developing visualizations of data on the HIV epidemic from the CDC, health departments, and analytics.

Data on federal funding from the CDC, HRSA, HOPWA, and SAMHSA were obtained from the Kaiser Family Foundation State Health Facts.[15]

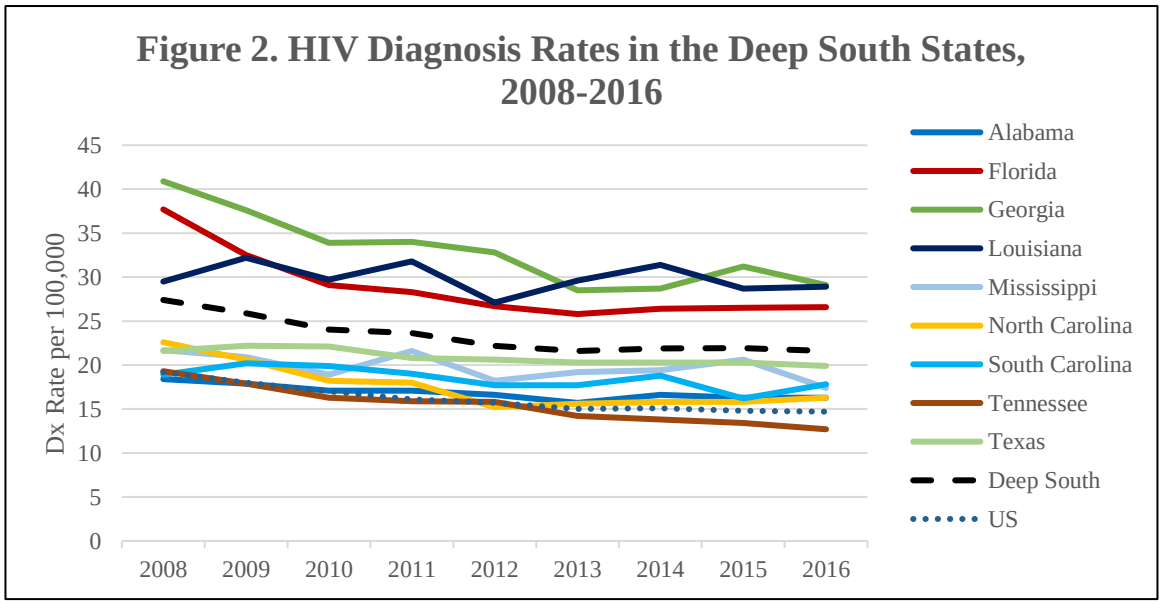
RESULTS

HIV/AIDS Diagnoses



Examination of HIV diagnosis rates for the nine-year period 2008-2016 identified a consistent trend in rates by U.S. region with the Deep South having the highest diagnosis rates for all years followed by the rest of the South and the Northeast (Figure 1). From 2008-2016, the Deep South states contained the majority of new HIV diagnoses in terms of both number of cases and percent of all cases in the U.S. In 2016, 40% of HIV diagnoses were in the Deep South, which only comprises 29% of the U.S. population.

In 2016, of the Deep South states, Georgia and Louisiana had the highest HIV diagnosis rates at 29.1 and 28.9 per 100,000 population, respectively, followed by Florida at 26.6 per 100,000 population. (**Figure 2**).

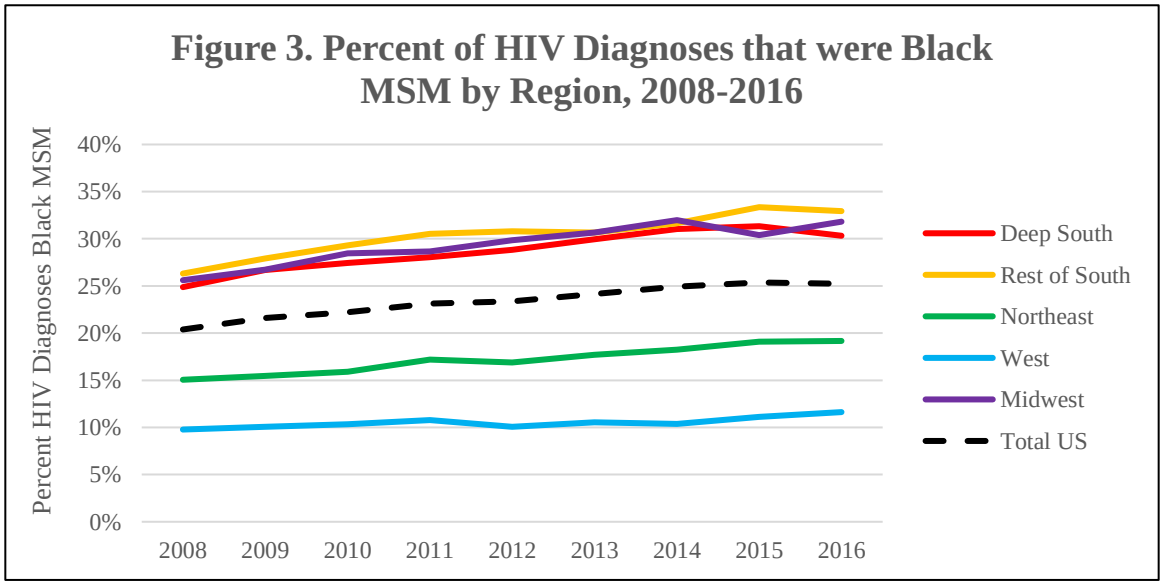


Demographic Characteristics

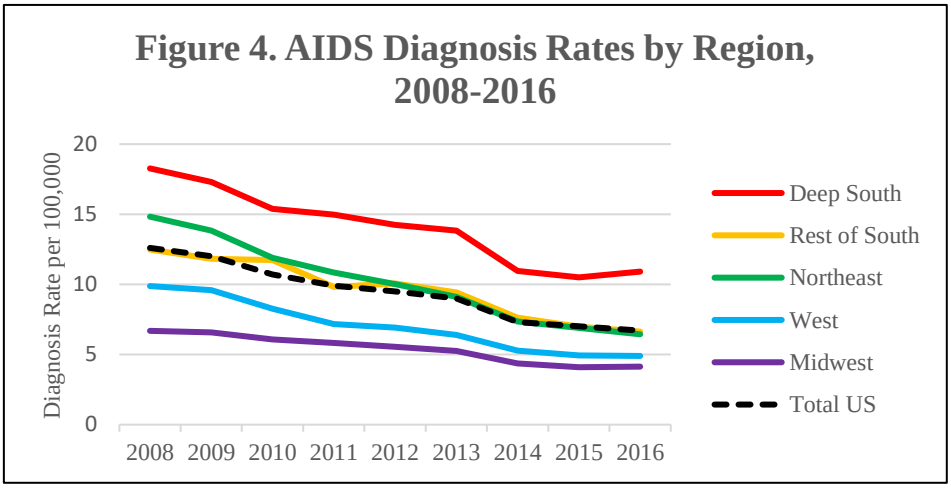
The majority of HIV diagnoses in the Deep South were among individuals of black or African American race, hereafter referred to as black, each year from 2008 through 2016. The racial disparity in HIV diagnosis rates has been consistent in the Deep South states and throughout the United States, with more blacks per 100,000 population being diagnosed each year than whites. For example, in 2016, for every 100,000 blacks in the Deep South states, 61 more blacks were diagnosed with HIV than for every 100,000 whites. In the Deep South, the percentage of individuals newly diagnosed with HIV that were black decreased from 2008-2016 (from 56.4% to 52.7%), while the percentage of newly diagnosed individuals that were Hispanic/Latino increased from 16.8 in 2008 to 22.4 in 2016. The percentage of new diagnoses that were Hispanic/Latino increased in the U.S. overall from 20.0% in 2008 to 24.7% in 2016. In 2016, over one-third (39%) of the 9,750 Hispanic/Latino individuals diagnosed with HIV resided in the Deep South.

Surveillance data from 2008-2016 indicated that the *percentage* of HIV diagnoses that were female declined over time in the Deep South (26.8% in 2008 to 20.4% in 2016), and in the U.S. overall (24.2% to 20.2%). The HIV *diagnosis rate* among women also declined over time in the Deep South and the overall U.S. A large disparity in diagnosis rates between black and white women remains in the Deep South and the overall U.S. In 2016, the HIV diagnosis rate for black women in the Deep South states was 28.5 while the rate for white women was 2.5 per 100,000.

In contrast to the decline in the percentage of individuals diagnosed with HIV who were female, the percentage of HIV diagnoses that were men who have sex with men (MSM) increased over time in the Deep South (56.7% in 2008 to 65% in 2016) and in the U.S. overall (59.7% in 2008 to 66.3% in 2016). All regions experienced an increase in the percentage of new diagnoses that were black MSM; however, this increase was the largest in the South. In contrast, the percentage of individuals diagnosed with HIV that were white MSM remained relatively constant over time in the Deep South states. In the Northeast, the increases in the percentage of HIV diagnoses were fairly similar between white and black MSM. Although all Deep South states experienced increases in the percentage of individuals diagnosed with HIV that were black MSM (**Figure 3**), South Carolina had the greatest increase from 2008 to 2016 (18.3% to 22.3%) followed by North Carolina (30.2% to 41.02%) and Georgia (38.2% to 47.7%). In addition, in 2016, over half (51%) of black MSM diagnosed with HIV in the U.S. resided in the Deep South.

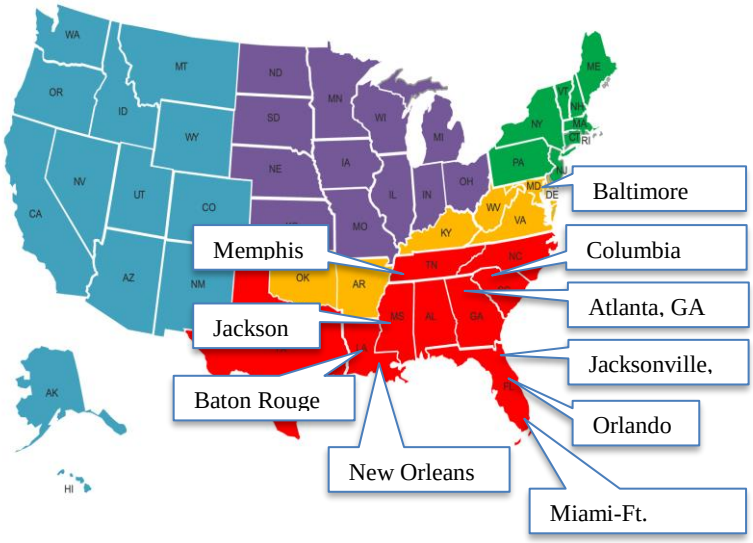


AIDS diagnosis rates followed a similar pattern to HIV diagnosis rates. AIDS diagnoses declined in all regions between 2008 and 2016, however, AIDS diagnosis rates have plateaued in recent years in the Deep South in contrast with the other U.S. regions. All Deep South states had AIDS diagnosis rates higher than the U.S diagnosis rate in 2016, and the Deep South region consistently had the highest AIDS diagnosis rates from 2008-2016 (**Figure 4**). The Northeast region had the next highest AIDS diagnosis rates from 2008-2016. For all of the nine years of the time period described herein, the Deep South contained the majority of new AIDS diagnoses in terms of number of cases and percent of all cases in the U.S.

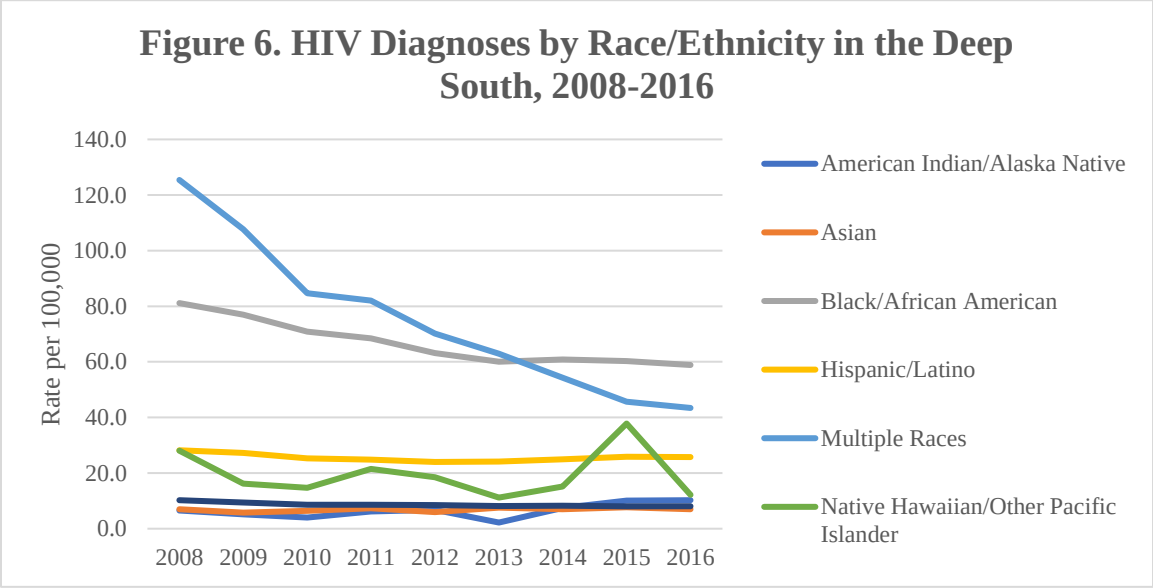


Within the Deep South, AIDS diagnosis rates varied, with Louisiana and Georgia having the highest AIDS diagnosis rates followed by Georgia and Florida. In 2016, the Deep South accounted for 44% of AIDS diagnoses in the U.S. despite only accounting for 29% of the population. The Deep South also contained nine of the 10 metropolitan areas with the highest AIDS diagnosis rates in 2016 (**Figure 5**).[17]

Figure 5: Ten MSAs with the Highest AIDS Diagnosis Rate in 2016

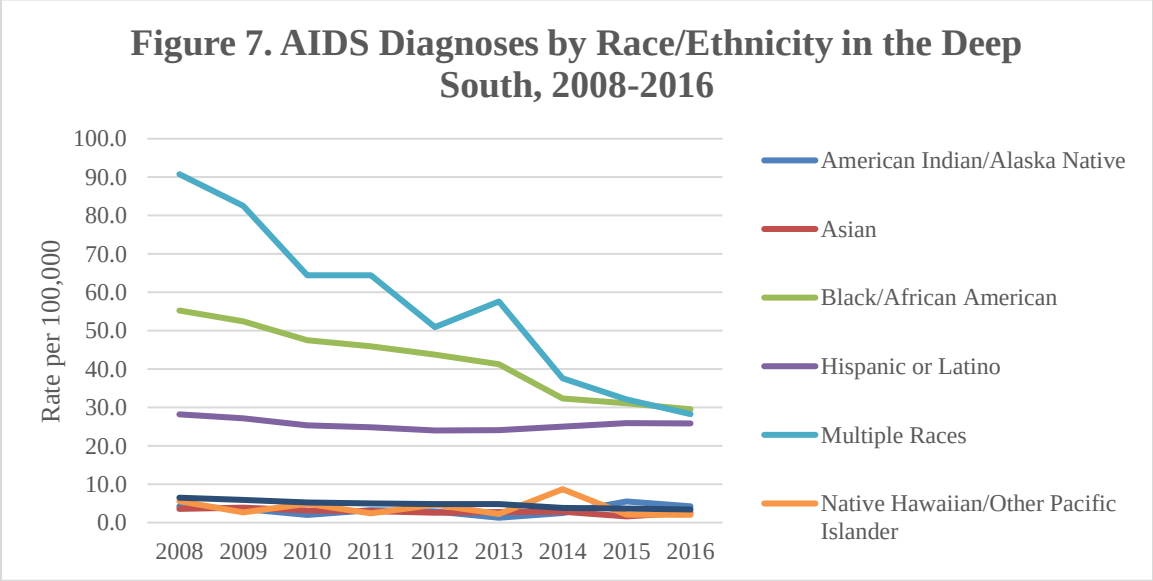


African-Americans comprised the majority of AIDS diagnoses in the Deep South (range 56-58% for all years, 2008-2016.) This percentage has shown very little change over time. The percentage of AIDS diagnoses that were female declined somewhat over time in the



Deep South (29.6% in 2008 to 26% in 2016) and in the U.S. overall – 26.3% to 24.1%. The percentage of individuals diagnosed with AIDS that were black MSM increased (21.7% in 2008 to 30.3% in 2016) over time in the Deep South while this percentage slightly declined for white MSM over time (15.7% to 12.0%)

In the Deep South, HIV and AIDS diagnosis rates have declined among individuals of black or multiple races but still remained slightly higher than the rates of Hispanic/Latinos and considerably higher than whites (**Figures 6 & 7**).

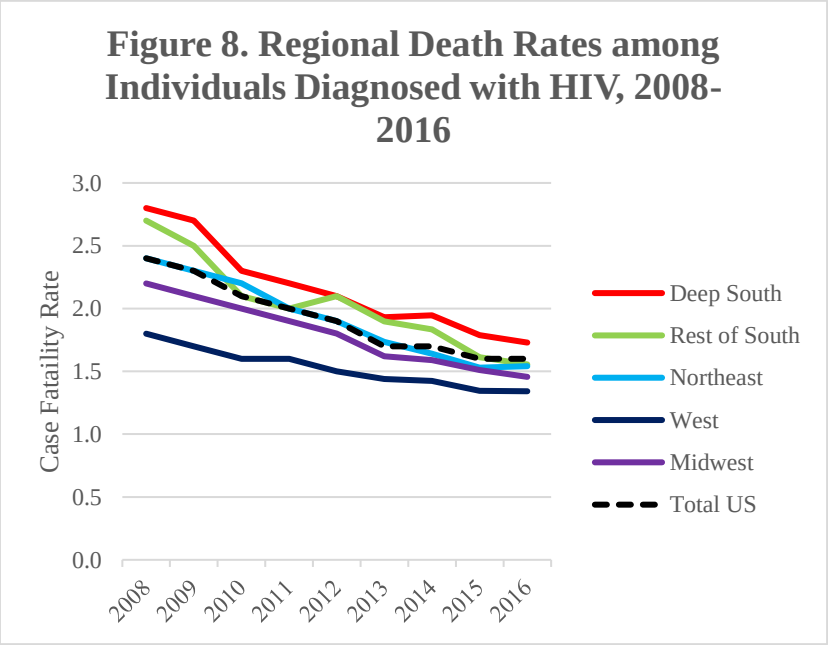


HIV/AIDS Prevalence

The Deep South had both the highest number (356,395) and percentage (35%) of individuals living with HIV of any region from 2008-2016. However, HIV prevalence rates, which are the number of individuals estimated to be living with HIV per 100,000 population, were highest in the Northeast from 2008-2016, followed by the Deep South. Similarly, the Northeast had the highest AIDS prevalence rates (defined as having ever been classified as Stage 3 HIV disease), likely due to the origination of the U.S. HIV epidemic in the Northeast region. Florida consistently had the highest HIV and AIDS prevalence rates within the Deep South followed by Georgia and Louisiana.

HIV/AIDS Deaths

We examined deaths among individuals diagnosed with HIV (Figure 8). Death rates among individuals diagnosed with HIV differ from conventional death rate calculations, which include both individuals living with and without HIV in the denominator to describe HIV mortality in a population overall. HIV death rates among individuals diagnosed with HIV may reflect the extent to which individuals living with HIV are not engaged and/or retained in medical care, among other factors.

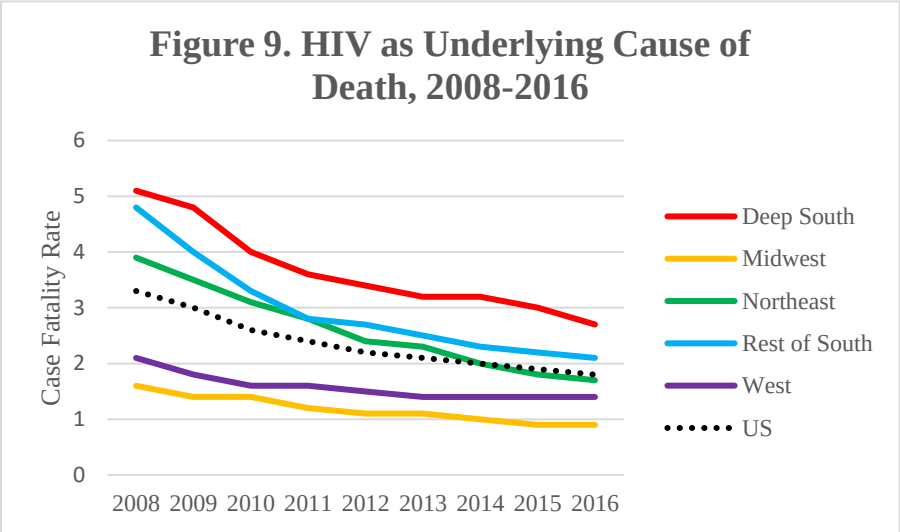


From 2008-2011, the death rates among individuals diagnosed with HIV were the highest in the Deep South, followed by the Northeast and rest of the South (**Figure 8**). However, from 2012-2016 the death rates among individuals diagnosed with HIV were the highest in the Deep South and rest of the South, which had nearly identical rates, followed by the Northeast.

The Deep South states had the largest number of HIV-positive individuals who died in 2016 (n=6,045; 39% of all deaths of HIV-positive individuals in the U.S. in 2016) and the largest number of individuals who died in the time period 2008-2016 (n=58,477). HIV death rates have decreased over time in all Deep South states consistent with the overall U.S. trend. Of the Deep South states, Alabama, Louisiana, and Mississippi generally have experienced the highest death rates (2008-2016) among individuals diagnosed with HIV.

Although the death rate among individuals diagnosed with HIV provides vital information regarding deaths among persons who have been diagnosed with HIV, these statistics may not clearly reflect deaths attributable to HIV disease rather than due to other chronic comorbidities

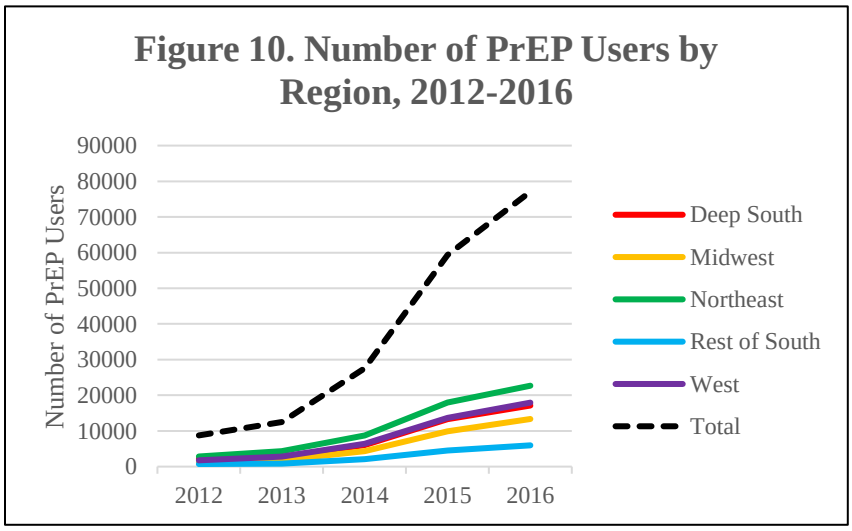
and acute illnesses not related to HIV. When CDC data regarding death rates in 2008-2016 with HIV as an underlying cause were examined, the Deep South had the highest death rates attributable to HIV of any region (**Figure 9**).



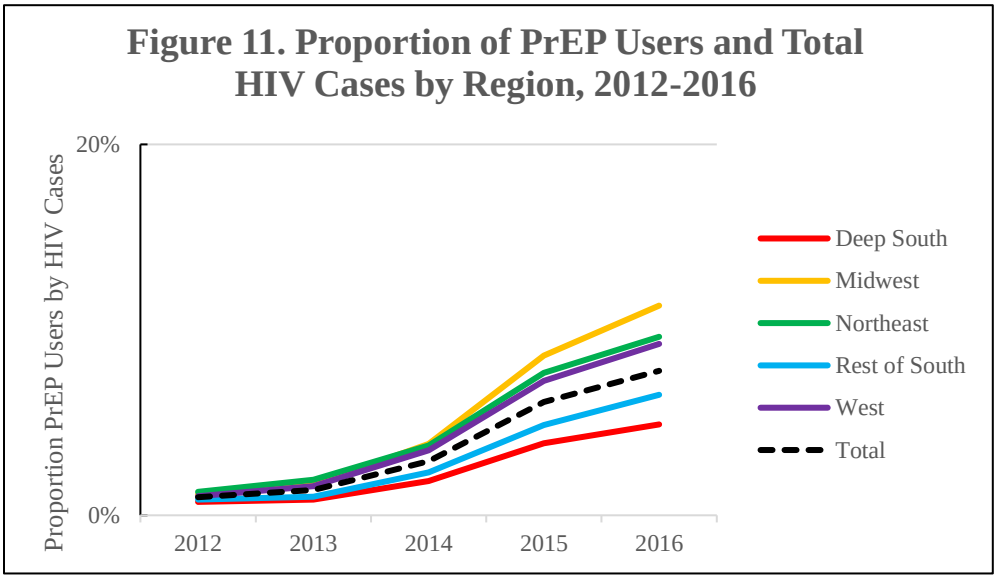
From 2008-2016, 29,799 individuals in the Deep South states died of HIV as the underlying cause of death, representing 43% of deaths in the U.S. where HIV was the underlying cause. CDC data regarding death rates due to HIV indicated that all Deep South states had higher death rates than the U.S. overall from 2008-2015, however Tennessee dropped below the U.S. overall rate in 2016. Florida, Georgia, Louisiana, South Carolina, Mississippi, and Texas all appear in the top 10 highest states for deaths with HIV as the underlying cause, and all the Deep South states are in the top 20.

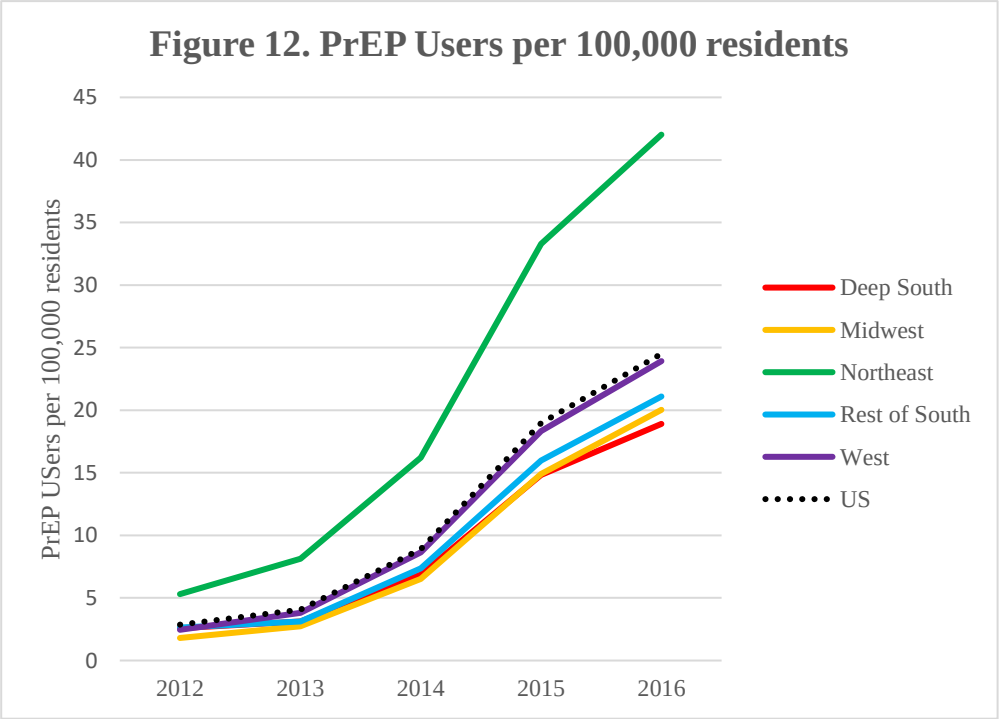
PrEP UTILIZATION

Pre-exposure prophylaxis (PrEP) is a pill regimen taken by individuals at risk for acquiring HIV that prevents acquisition of the virus if taken daily as prescribed. PrEP has been shown to decrease risk of HIV infection by 92% if taken regularly. Despite evidence of its effectiveness, dissemination of PrEP is lagging in some regions and demographic groups.[28] From the data compiled on PrEP use (with findings publicly available on AIDSVu), it is apparent that the Deep South has the third highest number of individuals utilizing PrEP (Figure 10) of any of the geographic regions. However, when the number of PrEP users is examined per number of individuals living with HIV (used as a proxy for need in a region), the Deep South has the lowest proportion of individuals utilizing PrEP among regions, indicating lower dissemination of PrEP in the population (Figure 11). In addition, in 2016, the Northeast region had approximately twice the rate of PrEP use (47.4 PrEP users per 100,000 population) compared to the West (28.1 PrEP users per 100,000 population), the South (22.6 PrEP users per 100,000 population), and the Midwest (23.5

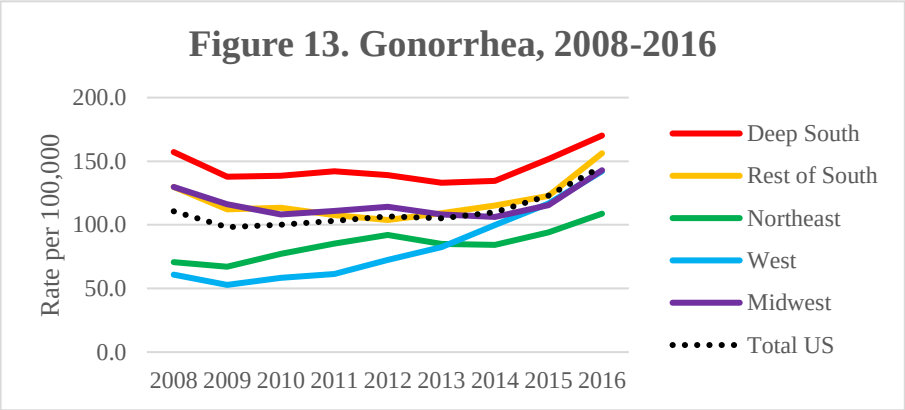


PrEP users per 100,000 population) regions. When usage of PrEP is examined per 100,000 population the findings are similar, as the Deep South also had the lowest rate of utilization of any region (Figure 12).

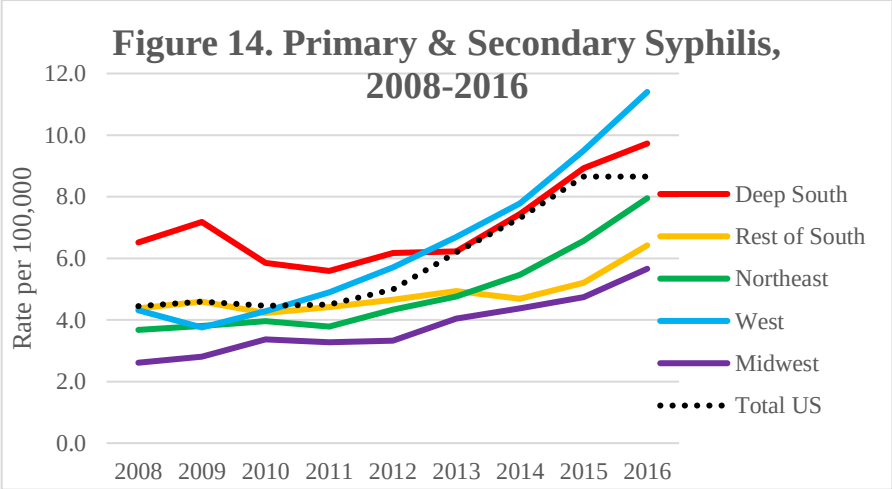




Sexually Transmitted Infections (STIs)

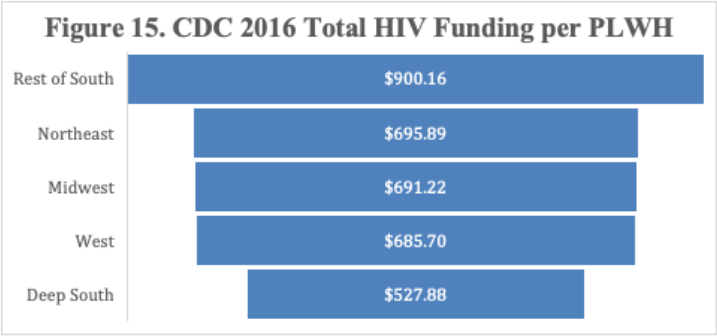


Gonorrhea, syphilis, and chlamydia have been shown to increase the risk for acquiring HIV.[18] CDC epidemiologic data indicate that the rates of infection for chlamydia and gonorrhea were consistently higher for individuals living in the Deep South from 2008-2016 as compared to other U.S. regions (**Figure 13**). The Deep South region also had the highest rates of early latent syphilis from 2008-2016 and the highest primary and secondary syphilis rates from 2008-2015. However, the West experienced a notable increase in primary and secondary syphilis diagnoses and surpassed the primary and secondary syphilis rate of the Deep South in 2016 (Figure 14).



Federal funding for HIV prevention and care

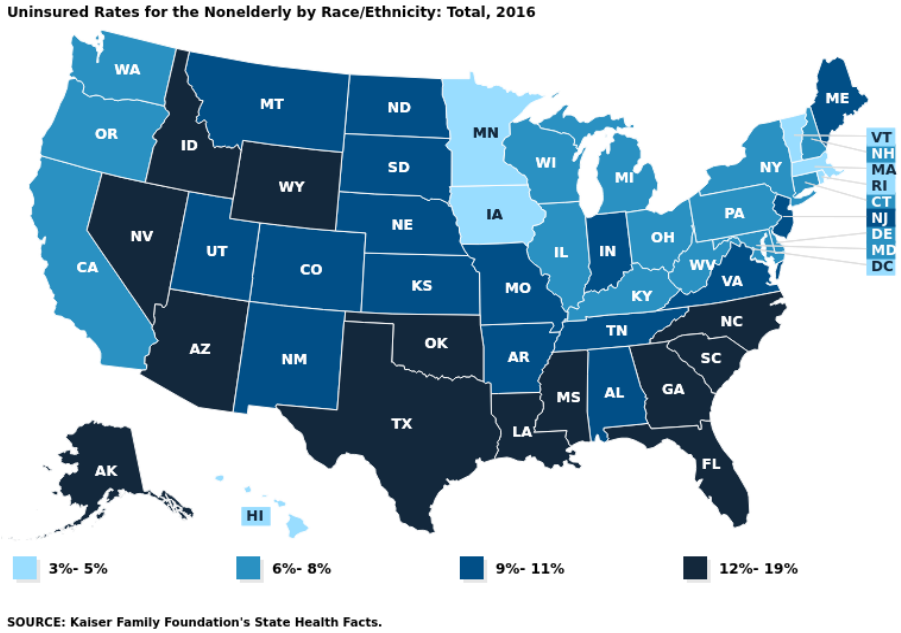
HIV care and prevention is financed through several federal funding sources including the CDC, Ryan White Care Act, HOPWA, and SAMHSA. We examined the total amount of these federal funds distributed in 2016 per person living with HIV and found that the Deep South received less funding per individual living with HIV ($2965.98) than other regions: Northeast ($3499.70), Rest of the South, ($3490.21), West ($3079.80), US average ($3167.79). The disparity in funding for the Deep South was primarily driven by differences in CDC funding and Ryan White funding per person living with HIV. For Ryan White funding, the Deep South had just under $100 less per PLWH ($1993) than the US average ($2091) and $300 less than the Northeast ($2321), which had the highest funding per PLWH. For CDC funding, the allocation per PLWH ($528) was slightly over $100 less than the US average ($653) and substantially less than the allocation per PLWH for Rest of the South ($900) (Figure 15). In the case of CDC funding, use of the measure per PLWH is a proxy for measuring need for prevention services in each region. In 2015, the level of funding per person living with HIV (PLWH) in the Deep South was also less than other US regions except the Midwest. Federal



funding per PLWH was comparable between the Deep South and US overall for Ryan White, SAMHSA, and HOPWA funding. However, for CDC funding there was a disparity of $100 per person living with HIV between the Deep South ($494/PLWH) and the US overall ($596/PLWH). Similarly, in 2014, there was a gap in overall funding per PLWH (HRSA, CDC, SAMHSA, Ryan White) between the Deep South ($3041.90/PLWH) and the overall US ($3151.70/PLWH). Mirroring previous years, this inequity was primarily due to the Deep South receiving lower levels of CDC funding per PLWH ($503.60) compared to the US overall ($585.60).

INSURANCE STATUS AND THE AFFORDABLE CARE ACT

In 2016, six of the Deep South states were ranked among the 10 U.S. states with the highest uninsured rates including Texas, which had the highest proportion of residents without health insurance of any state in the U.S.[19] All of the Deep South states except Louisiana (8%) had higher proportions of uninsured individuals than the U.S. average (9%).



To date, Louisiana is the only Deep South state to have adopted and implemented Medicaid expansion. Nine of the 14 states that have not opted to expand Medicaid are in the US South. An analysis of Medicaid Expansion under the Affordable Care Act (ACA) conducted by the Kaiser

Family Foundation (KFF) found that 92% of Americans that were in the "coverage gap," meaning that they were not eligible for Medicaid because their state of residence had not elected to participate in Medicaid Expansion but their income was below the lower limit for ACA Marketplace premium tax credits, resided in the South. The South has higher numbers of poor uninsured adults than in other regions and more limited Medicaid eligibility than other regions. The KFF analysis estimated that nearly 2.2 million individuals residing in the Deep South were in the coverage gap.[20]

Another KFF study examined the outcomes of Medicaid expansion, and found that benefits experienced by the Medicaid expansion states were not matched in non-Expansion states including increases in access to care, affordability of care, such as less out-of-pocket costs and unmet medical need, and some improvements in health outcomes including cardiac health and infant mortality as well as reduction in state uncompensated care costs.[21]

DISCUSSION

The analyses outlined in this manuscript expand on the findings from a previous study of HIV epidemiology in the U.S. South from 2008-2013 by including recent years of HIV surveillance data (2014-2016) to examine epidemiologic trends and to allow for a longer time period of study. Recent epidemiologic trends mirror those identified in the previous study in identifying that the Deep South has been and remains disproportionately affected by HIV. For the nine-year period of study, the Deep South states had the highest HIV and AIDS diagnosis rates along with the highest number of individuals diagnosed with HIV and AIDS. In 2016, 43% of new HIV diagnoses were within the Deep South while the Deep South states contained only 29% of the U.S. population. The Deep South also continues to have the highest rates of chlamydia, gonorrhea, and early latent syphilis of any U.S. region. STIs have been strongly associated with future HIV acquisition,[18] raising concerns regarding a continued disproportionate impact of HIV in the Deep South.

The Deep South and U.S. overall experienced a shift in the demographic composition of HIV diagnoses in the last nine years with the proportion of new diagnoses among women declining and the proportion of new diagnoses increasing among black MSM. In the Deep South, just over one-quarter of those diagnosed with HIV in 2008 were black MSM compared to nearly one-third (30.3%) in 2016. In addition, in 2016, just over half (51%) of black MSM diagnosed with HIV in the U.S. resided in the Deep South.

Consistent with previous years, the Deep South continues to have the highest death rates attributable to HIV disease (deaths of individuals where HIV disease was the underlying cause of death/100,000 population) followed by the Northeast. Due to the emergence of effective HIV medications, these HIV-attributable deaths should be largely preventable from a medical standpoint. Higher death rates from HIV may reflect barriers to timely testing and treatment such as HIV-related stigma, lack of transportation and housing, and inadequate availability of HIV medical providers.

There were differences in HIV epidemiology among the Deep South states. Louisiana, Florida and Georgia had particularly high HIV and AIDS diagnosis rates and rates of death attributable to HIV. Mississippi and South Carolina also had some of the highest AIDS diagnosis rates and death rates within the Deep South. However, all Deep South states had AIDS diagnosis rates and HIV death rates (where HIV was an underlying cause) greater than the U.S. average.

Differences in federal funding for HIV prevention and care by region were also identified. The Deep South had the lowest overall federal funding (includes SAMHSA, Ryan White, HOPWA and CDC allocations) per person living with HIV of any region in 2016, the most recent year of data available. The funding disparity was primarily resultant from less CDC and Ryan White funding per person living with HIV. The finding regarding less CDC funding per PLWH in the Deep South is consistent with funding disparities identified by region in 2014 and 2015. However, in 2014 and 2015, Ryan White funding was comparable by region. Medicaid coverage is also less available in most of the Deep South, as this region generally has the most stringent financial eligibility criteria and to date, only one of the nine Deep South states opted to implement Medicaid Expansion. Failure to adopt Medicaid Expansion in the Deep South has resulted in individuals living with HIV remaining uninsured and dependent on an overburdened Ryan White program for basic HIV health services.

The longitudinal nature of the epidemiologic data demonstrates that the significant impact of HIV in the Deep South is not unique to one specific year or a brief period of time. Rather, these trends have been consistent over the last nine years of data available and indicate a critical need to strengthen efforts to reduce HIV transmission and mortality within the region. The lower diffusion rate of PrEP in the Deep South also demonstrates a critical need for intervention, as this is a key strategy for reducing and ultimately eliminating HIV transmission.

Since our last report describing trends in HIV epidemiology in the US Deep South, there has been a much-needed influx of public and private funding targeting the HIV epidemic in the South**.** In 2016, the CDC released a funding opportunity, PS17-1704 designed to "implement comprehensive HIV prevention programs to reduce morbidity, mortality, and related health disparities among young men of color who have sex with men…; young transgender persons of color…and their partners who are at high risk of acquiring HIV." In contrast to the 2015 CDC HIV prevention funding for community-based organizations (PS15-1502) highlighted in the last report regarding HIV in the Deep South, applicants for PS17-1704 funding were not restricted to CBOs in large metropolitan areas. Also in contrast to PS15-1502, 48% of total PS17-1704 funding went to the South, which came close to mirroring the 52% of new HIV diagnoses represented by the South in 2015.[22]

The South has higher HIV diagnosis rates in smaller metropolitan (50,000 – 499,999 population) and rural areas compared to other regions and in at least 4 Deep South states, more than half the people living with HIV reside outside large metropolitan areas.[23] Despite the fact that applicants for PS17-1704 funding were not restricted to those in large metropolitan areas, 93% of the PS17-1704 funding for the South and 100% of the funding for the Deep South was distributed to CBOs in large metropolitan areas (MSA ≥ 500,000 population).[22] Funding, however, did not follow the epidemic within the Deep South Region.

In February 2019, the US Department of Health and Human Services announced a ten-year plan to end the HIV epidemic in the United States.[24] The initiative has as its goals to reduce new HIV infections by 75% in five years and by 90% in ten years. In the first 5 years, the initiative will target 48 highest burden counties, Washington, D.C., San Juan, Puerto Rico and significantly, 7 states with a substantial rural HIV burden. Almost half of the counties plus Washington DC and 6 of the 7 targeted states are in the US South in recognition of the significant HIV burden in the Southern Region.[24] As of the writing of this report, the exact funding levels for the plan are unknown.

In the private sector, in 2017 Gilead Sciences launched its COMPASS (COMmitment to Partnership in Addressing HIV/AIDS in Southern States) Initiative, a 10-year, $100 million

initiative which, in partnership with community-based organizations, will work to combat the HIV/AIDS epidemic in the Southern United States.[9] As part of the initiative, Gilead is funding three coordinating centers: Emory Rollins School of Public Health, the Southern AIDS Coalition and the University of Houston Graduate College of Social Work to lead the provision of trainings and funding related to capacity building, stigma reduction and culturally appropriate care, and mental health, substance use and trauma-informed care. Initially the work of the coordinating centers is targeted on the nine-state Deep South region.

ViiV Healthcare has also invested significant resources in the South with the launch in 2015 of its ACCELERATE! Initiative, a four-year, $10 million commitment aimed at improving HIV outcomes for Black gay men in Baltimore and Jackson, MS, and its Positive Action Southern grants focused on expanding and enhancing linkage and adherence to care services for people living with HIV in the Southern U.S.[25]

In addition, the Elton John AIDS Foundation[26] continues to provide funding support to organizations doing work in addressing HIV in the U.S. South. In 2017, a group of funders brought together by Funders Concerned About AIDS that included the Ford Foundation, the Elton John AIDS Foundation, Gilead Sciences, ViiV Healthcare, and Johnson and Johnson, launched the Southern HIV Impact Fund administered by AIDS United to provide grants to community-based organizations around the South working on ending the HIV epidemic and reducing health disparities.[27]

These funding initiatives are encouraging as holistic approaches that include private and public partnerships and that address the multiple factors that contribute to the disproportionate epidemic in the South such as lack of resources, poor HIV infrastructures, regional resource inequities, HIV-related stigma, and high STI rates. More such resources are needed to adequately address HIV in the region. It is also important that the South, particularly the Deep South, receive a comparable share of HIV care and prevention funding and that funding is distributed consistent with the geographic distribution of the epidemic. It is essential to devise effective strategies to build the infrastructure of services related to HIV prevention and care, particularly in the less densely populated areas where service gaps and HIV-related stigma may be most prominent.

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