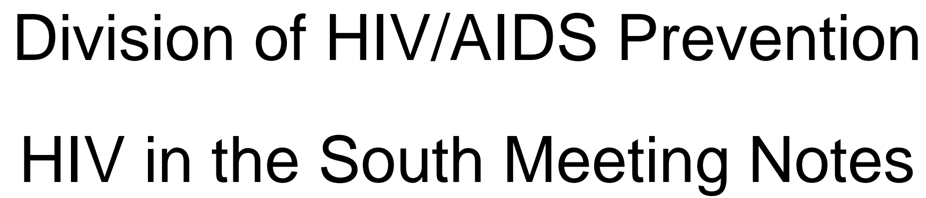

Division of HIV/AIDS Prevention

HIV in the South Meeting Notes

Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

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Disclaimer: This document is a summary of discussions from the HIV in the South Meeting held on April 19, 2017. The content of this document is not intended to represent the collective view of participants. It reflects ideas and thoughts shared by individual participants attending the meeting.

Summary

On April 19, 2017, the Centers for Disease Control and Prevention (CDC) Division of HIV/AIDS Prevention (DHAP) held the HIV in the South Meeting in Atlanta, Georgia. A town hall format allowed invited participants to provide individual feedback on addressing the HIV-related health disparities in Deep South states (Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Texas), as outlined in national goals for addressing health disparities. Invited participants were individuals with experience and expertise in conducting HIV prevention efforts in these states.

The agenda (Appendix A) included a welcome by DHAP Associate Director for Health Equity Donna Hubbard McCree, PhD, MPH, RPh and Kirk D. Henny, PhD. Jonathan Mermin, MD, MPH, RADM and Assistant Surgeon General, USPHS and Director, National Center for HIV/AID, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) and DHAP Director Eugene McCray, MD, made opening remarks. The meeting also included facilitated and roundtable discussions and a DHAP leadership question and answer panel.

This report provides an overview of key presentations and a summary of key outcomes from the facilitated and roundtable discussions. The report does not represent the collective opinions and perspectives of all invited participants. Additionally, the information in the report should not be considered to be formal recommendations by the CDC. The report serves to summarize the information that was presented and discussed at the meeting.

Opening Remarks

Sustained investments in HIV prevention and treatment have yielded major successes—saving the lives of many. We have been able to achieve a steady decline in new HIV infections as the number of annual HIV infections in the United States fell 18% between 2008 and 2014—from an estimated 45,700 to 37,600 cases.

While HIV prevention and treatment efforts are seeing results, health disparities are causing these efforts to have unequal impact in different communities: new infections increased in Latinos, men who have sex with men (MSM), and persons of color. Survival rates show alarming differences. Southern state mortality rates are three times higher than in other states.

In response, CDC realigned funding and programmatic efforts to address these issues in the South. The HIV in the South meeting is one way that CDC is gathering information to address the ways CDC can do more and make a difference in HIV prevention in the South.

CDC's approach to addressing HIV is to align resources and activities to focus on the right people, right places, and right practices. At this critical point in the epidemic, it is important not to lose ground. CDC priorities in HIV prevention include increasing knowledge of HIV status, preventing new infections, reducing HIV transmissions, and developing interventional and surveillance response capacity.

While condoms are still an important tool in the HIV prevention toolbox, pre-exposure prophylaxis (PrEP)[1]--a daily pill that can be taken by people at very high risk for HIV to lower their chances of

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[1] Pre-exposure prophylaxis (or PrEP) is when people at very high risk for HIV take HIV medicines daily to lower their chances of getting infected.

getting infected--is a potential game changer. Promoting syringe services programs and access to sterile injection equipment, keeping people living with HIV in care to achieve viral suppression, improving data systems, and supporting surveillance activities like Data to Care[2] (D2C) are prevention efforts that can move progress forward. With these new HIV prevention tools and targeting efforts to the right geographic areas, the end of the epidemic is within reach.

Group Discussion of Key Challenges

The meeting began with a facilitated discussion of the key challenges participants encounter in delivering HIV prevention and care services (e.g., HIV testing; linkage, reengagement and retention in care; behavioral and biomedical prevention interventions) for gay and bisexual men, young black men who have sex with men (referred to as MSM), black women, Hispanic/Latino MSM, and transgender persons.

A. **Expected outcomes**- Participants were asked to state an expected outcome from the meeting. The following provides a summary of the expected outcomes provided by participants.

1. New ideas and innovative program approaches to HIV prevention efforts, especially for young black men, young MSM, transgender persons, and women of color
2. New collaborations for addressing HIV prevention efforts
3. Methods for addressing HIV-related stigma in the South
4. Discussion of opportunities to build the infrastructure and the capacity to address structural and contextual factors (i.e., racism and genderism) affecting HIV prevention efforts in the South
5. Methods to make PrEP use more mainstream in the South and promote its use in disproportionately affected communities
6. An understanding of what other health departments are doing and the challenges they face with delivering HIV prevention efforts in their jurisdictions
7. How to use limited resources to develop the care and prevention infrastructure needed to address HIV in the South
8. Discussion of opportunities to expand HIV prevention efforts in correctional settings through collaborations with organizations in the South
9. Methods to identify and include HIV-positive individuals in key HIV prevention leadership positions
10. Discussion of new funding opportunities that might improve HIV prevention efforts in the South

[2] The Data to Care program provides a framework for state and local health departments to use HIV surveillance data to guide the identification and linkage to care for individuals diagnosed with HIV.

B. **Challenges**- There were several experiences that meeting participants repeated when discussing the challenges they personally experience in providing HIV prevention services. The discussions centered on nine key areas:

1. **HIV-related stigma**: Stigma associated with risk for and living with HIV infection impedes the delivery of prevention efforts, especially for gay and bisexual men and transgender persons. As a result, persons living with HIV are not being diagnosed and linked to care.

2. **Cost of and availability of prevention efforts**: The costs of HIV prevention services like PrEP are prohibitive, especially in non-Medicaid expansion states. Individual participants expressed that efforts are needed to identify sources of funding for individuals who cannot afford prevention and treatment services.

3. **Provider barriers**: Healthcare provider barriers discussed included poor communication skills, difficulty discussing HIV testing, a lack of cultural competence in providing care for sexual minority populations, lack of time to deliver and no reimbursement for HIV prevention services. These barriers are negatively affecting efforts to diagnose persons living with HIV and provide prevention services for persons at risk of infection.

4. **Geographical challenges**: Persons living with and at risk for HIV infection who reside in rural areas face numerous challenges including a lack of quality services and providers. Individual participants expressed a desire for federal funding opportunities that include a focus on services specifically targeted to and tailored for rural areas.

5. **Reporting requirements that only focus on HIV specific activities**: One challenge individual participants raised was the need to provide non-HIV services (e.g., housing assistance, substance abuse treatment, transportation) for some of their clients before being able to get these clients in for testing and other prevention services. However, CDC grantees' performance is only based on their HIV prevention services, and not all the efforts that surround HIV prevention service delivery for their clients.

6. **Decentralized reporting efforts across federal agencies**: Individual participants expressed that federal agencies often require different reporting requirements for HIV prevention efforts delivered by grantees. This creates burden among grantees and leads to less efficient prevention efforts.

7. **Immigration status**: Fear of immigration status may prevent some persons from seeking prevention and care service. Continuity of care may be especially difficult for persons who are detained due to their immigration status. Individual participants expressed that one barrier to their HIV prevention efforts included the lack of clear policies to address immigration status in the communities they serve.

8. **Lack of prevention efforts for HIV-negative persons**: For the past decade, the focus of funding by federal agencies shifted to identifying persons who are newly infected, at the exclusion of services for HIV-negative individuals. Individual participants noted that funding in the South, given the HIV prevalence in the region, was not sufficient to deliver services for persons at risk of HIV infection.

9. **Training**: Providers lack the training and capacity to deliver prevention efforts like PrEP to gay and bisexual men

Summary of Roundtable Discussions

Participants were assigned to roundtables to discuss the following:

A. What activities (e.g., innovative solutions, effective strategies, lessons learned, best practices) have you used in your jurisdictions to address challenges for delivering HIV prevention services to gay and bisexual men, young black MSM, black women, Hispanic/Latino MSM, and transgender persons; and
B. Given the activities that you used, describe the key partnerships and collaborations created to address the key challenges.

Participants also discussed key partnerships and collaborations at the local, state, and federal level that could be used to address HIV-related health disparities for the populations they serve. This section summarizes the recurring experiences discussed by participants.

A. **Activities** – Participants described activities (e.g., innovative solutions, effective strategies, lessons learned, best practices, etc.) utilized to address challenges for delivering HIV prevention services to specific high risk populations

    1. **Ideas for engaging gay and bisexual men, Hispanic/Latinos, and transgender persons**: Some ideas that participants discussed included using client referrals to identify persons at risk of HIV infection, using targeted marketing posted to online dating sites and apps, employing bilingual staff to assist with community engagement, providing outreach to organized networks of young MSM, and using race- and gender-matched providers for prevention efforts.

    2. **Ideas for promoting PrEP use**: Participants provide PrEP education during parties they host with providers who conduct HIV testing. Participants also spoke about how they established a PrEP workgroup in collaboration with a federally-qualified health center and opened a PrEP clinic at the health department to provide services for uninsured persons.

    3. **Developing a culturally competent workforce**: Strategies participants used to improve cultural competence included hiring staff who are members of the populations they serve; providing training for all staff members on key issues such as race, class, gender, sexuality, and trauma; and training staff to avoid the use of terms that alienate key populations when discussing risk. Training and professional development for different types of health professionals including pharmacists and insurance navigators were also discussed as possible strategies.

    4. **Innovative service delivery models**: Persons living with and at risk for HIV infection may have competing priorities or challenges that impede access to or utilization of prevention and care services. Participants offered the following strategies to overcome barriers: addressing salient issues like housing, employment, stigma, and social support that may pose a challenge to engagement in HIV prevention and care; assisting individuals with creating personalized, holistic plans that can improve service utilization; using telemedicine and mobile units to gain access to hard-to-reach populations like rural populations, MSM

and transgender persons; and creating or using records systems to aid linkage to and retention in HIV care.

5. **Creative strategies to promote financial stability**: Financial instability threatens the ability of many organizations to sustain provision of important services. Potential strategies discussed to enhance organizations' financial stability over time included: diversifying funding sources; cross-training staff (e.g., Ryan White case managers cross-trained as health department disease intervention specialists); empowering and mobilizing community members to advocate for policies and resource allocation for HIV prevention and care; and educating and urging key individuals in positions of power to develop policies and allocate resources for HIV prevention and care.

6. **Building capacity among providers**: The HIV prevention landscape has changed to include a focus on use of data for the delivery of services and evaluation of program effectiveness. Participants stressed that providers need training on use of qualitative and quantitative data to evaluate program effectiveness and use of surveillance data to support data to care services.

7. **Client-centered services**: Participants adjusted the delivery and types of services to meet the needs of key populations in order to maximize engagement. This sometimes meant providing incentivized testing, which could both increase engagement and cause issues for testing efforts that are not incentivized.

8. **Innovative community engagement strategies**: Successful examples included telemedicine approaches; policies that support HIV testing, treatment and care in correctional settings; youth advisory boards; community-driven events located in areas and embedded in activities (e.g., concerts, parties) that target the population; town hall meetings; and partnerships between health departments and public schools that bring mobile unit testing to schools, health fairs, and communities.

B. **Partnerships** – Participants discussed partnerships and collaborations to address the following four key, interrelated challenges: addressing social determinants of health (SDH); reducing stigma; improving outreach; and providing training. Participants also discussed key federal partnership efforts needed to improve delivery of HIV prevention services in the South.

   1. **Partnerships to address SDH, holistic health needs and capacity-building**: These types of partnership efforts were supported by cross-organizational and interagency collaborations. Examples provided by participants included:

      - Establishing non-traditional partnerships, such as a consulates, after-school programs, pharmaceutical companies, and conservative churches;
      - Creating partnerships between colleges/universities and CBOs/health departments to provide technical assistance with grant development, access to subject matter expertise, and/or access to other university resources; and
      - Collaborating with state-level policy makers to develop a state-wide HIV prevention agenda.

2. **Partnerships to reduce stigma**: Efforts aimed at reducing stigma were supported by partnerships with key influencers and opinion leaders (e.g., celebrities, religious leaders and advocates) and partnerships between CBOs, health departments, and local public or private service providers.
3. **Partnership to improve outreach**: These types of partnership efforts relied on building trust and developing genuine relationships with communities and community gatekeepers. Other efforts included developing partnerships with juvenile detention centers to provider prevention services for at-risk adolescents.
4. **Partnerships to identify and provide training**: Participants developed reciprocal partnerships with non-HIV related organizations to build the capacity of both organizations and provide training. Training efforts included mentoring programs for health care providers at different stages in their professional careers.
5. **Partnerships at the federal level**: Participants stated that collaboration is needed across federal agencies to form non-traditional partnerships between health-focused agencies (e.g., CDC, HRSA) and other agencies (e.g., Department of Labor, Department of Housing and Urban Development, Department of Justice). Interagency collaborations can aid with coordination of services to address client needs, such as housing or employment, which are related to HIV outcomes; could improve distribution of funding across the HIV prevention and care continuum3; and could lead to consistency in requirements across federal agencies and more streamlined processes for organizations receiving funding from multiple agencies.

Senior Leaders Panel/Question and Answers

This session began with Opening Remarks from Dr. McCray followed by a question and answer session with Dr. McCray and the DHAP Senior Leaders.

A. Opening Remarks from Dr. McCray

CDC investment in HIV prevention funding has been increasing, with $339 million awarded to health departments across the United States, including $42 million of that money to CBOs. In 2014, HIV prevention funding to southern health departments totaled more than $113 million. Since the South bears a high distribution of HIV diagnoses, 26.7% of directly funded CBOs are in the South. CDC also supports demonstration projects—non-research projects to implement, conduct, and evaluate innovative high-impact prevention activities—in the region.

[3] The HIV care continuum—sometimes also referred to as the HIV treatment cascade—is a model that outlines the sequential steps or stages of HIV medical care that people living with HIV go through from initial diagnosis to achieving the goal of viral suppression (a very low level of HIV in the body), and shows the proportion of individuals living with HIV who are engaged at each stage.

B. Questions and Answers – This section provides a summary of the questions and responses discussed during the Senior Leader Panel.

How can CDC work with other federal agencies to regulate that Ryan White funds can be used for HIV-negative individuals at high risk?

Congress determines in which populations Ryan White funds can be used, not regulations by federal agencies.

> Note: HRSA added that while Ryan White funds are for care, some outreach, tracking, and testing can occur using those funds. Due to statute, Ryan White funds cannot pay for medicines like PrEP for HIV-negative individuals. There is a lot of flexibility in Ryan White, Part B supplemental funding. A supplemental funding opportunity is available that jurisdictions can use if their state qualifies.

However, CDC has been increasing engagement with federal agencies on HIV prevention strategies for individuals at high risk of HIV infection. CDC is working with HRSA on collaboration and integrated plans and also holds regular calls with HRSA on collaboration.

How will CDC use the feedback from the HIV in the South meeting?

CDC will look for recommendations and initiatives it can potentially include with wraparound issues that address diabetes, high blood pressure, and other health concerns. CDC will also use information from this meeting to inform discussions with CDC leadership about the potential for a comprehensive, integrated CDC prevention program initiative focused on the South, with HIV prevention included as one of several public health components.

Will CDC consider restructuring funding to demonstrate commitment to more experienced organizations? What are the barriers and challenges that CDC faces in considering funding streams in terms of tiers (i.e., new agencies learning from veterans) and giving flexibility to agencies that are committed and have demonstrated results?

Having more experienced organizations serve as mentors to less experienced organizations is a great idea. CDC determines funding for domestic HIV programs through a competitive process. CDC will continue to examine our current process to ensure we are receiving high quality funding proposals from all CBOs as well as proposals from new CBOs.

Getting grants in the transgender community is difficult because funds often go to agencies who know how to write grants. Can CDC help us to partner with agencies to gain grant-acquiring tools, particularly with agencies already providing services to the transgender community?

Capacity building in the transgender community is important for CDC. We suggest that organizations partner according to their expertise and organizational needs to increase effectiveness and maximize resources.

How is CDC dealing with transgender Latina issues around immigration?

As a public health agency, CDC does not have statutory authority to address immigration issues.

Engaging hard-to-reach populations, including black MSM and transgender women, in HIV prevention requires multiple approaches and services. Are there plans for CDC to provide funds for medical assistance for PrEP and medical preparation (e.g., labs)?

CDC does not have regulatory authority to provide funding for medications. A national federal workgroup [4] is working to identify the elements of a comprehensive PrEP delivery system.

Could CDC provide a marketing plan to market PrEP? What about a PrEP campaign for black women?

CDC does not currently have the resources to support a campaign dedicated to PrEP, including a specific PrEP campaign for black women.

To address the need for improved awareness about PrEP, CDC has developed a PrEP toolkit for providers and PrEP information was integrated into HIV testing and other existing campaigns. Additionally, CDC is working with medical provider partners to engage them in PrEP activities.

Due to structural issues in the South (e.g., transportation, health care access/insurance), should measures of success for HIV prevention programs look different in the South? Should the South be measured against a "different measuring stick?"

HIV prevention grantees have the opportunity to discuss their challenges when they report their data to us. CDC does not use different measures for different parts of the U.S. HIV funding opportunities include specific requirements that all funded jurisdictions must meet. It would not be feasible to direct certain measures of success to specific jurisdictions using those funding announcements.

Could CDC consider not just measuring things differently, but measuring different things? Our organizations stabilize clients by addressing housing, jobs training, etc., but we do not get credit for those activities that are needed before addressing HIV-related needs.

CDC is required to report to Congress HIV-related outcomes based on appropriated HIV prevention funding, such as HIV testing, linkage to care, condom distribution, etc. While CDC supports wraparound services such as mental health, housing, jobs training, etc., funded grantees cannot spend appropriated dollars for HIV prevention for those wraparound services, but are encouraged to make those linkages for clients.

Our agency needs a Medicaid specialist for working with Center for Medicare and Medicaid Services (CMS) on reimbursement for services. Our funding from CDC does not support that position, but the work of that position is valuable to what we do. What barriers keep the CDC from allowing us some flexibility to get to the core of what our need is?

CDC's programs are driven by Congressional appropriations and language. Funded organizations could potentially work through the state for Medicaid assistance or directly with CMS. However, CDC-funded grantees cannot use federal HIV prevention funds to hire a Medicaid specialist.

Can CDC fund positions in the health department to help CBOs work with billing issues?

[4] This workgroup includes representatives from Health and Human Services, Housing and Urban Development, Department of Justice, Labor, Veterans Affairs, and the Social Security Administration

CDC does not prohibit health departments from using its funding to assist CBOs with HIV-related billing. However, decisions to hire for those positions are made at the state or local level and some health departments are already providing this type of assistance.

Has CDC considered making it a requirement of health department funding that there are uniform basic services across the board that all are required to meet, e.g., giving a percentage back to the community they serve?

CDC understands that public health needs vary and are specific to each local environment. We structure our funding to allow jurisdictions the flexibility to respond to their unique public health needs and environments. CDC does not want to dictate at a national level every activity that can or cannot be conducted at a state or local level. CDC also remains mindful of the competing priorities and requirements of state and local health departments.

Has CDC given any thought to another initiative like Care and Prevention in the United States (CAPUS) just for the South?

Funding for CAPUS was provided through resources from the HHS Secretary's Minority AIDS Initiative Fund. Although CDC has not had discussions about a similar initiative, CDC could consider the suggestion for future discussion, if funding is available.

Is there a move to eliminate incentives from clinical programs, similar to interventions?

CDC does not prohibit organizations from giving participants incentives, although some CBOs choose not to provide them.

Closing Remarks

Dr. McCray closed the meeting by noting that during times of uncertainty and fiscal restraint, communication and building new, innovative partnerships are important for maximizing resources and expertise. These partnerships are especially important in rural areas of the South, which face many structural and financial challenges to addressing HIV prevention and care.

Addressing HIV in the South will require the combined efforts and expertise of all in attendance at this meeting. CDC is committed to continued collaborations with the community as we tackle this challenge. CDC hopes participants will continue to communicate any opportunities they see for addressing HIV in the South and across the United States.

Appendix

"HIV in the South" Town Hall Meeting
Division of HIV/AIDS Prevention (DHAP),
National Center for HI/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP)
Centers for Disease Control and Prevention (CDC);
April 19, 2017
Atlanta, Georgia

Agenda

April 18, 2017 6:30 pm – 8:30 pm	**Optional Pre-Meeting Networking Opportunity** Marlow's Tavern Emory Point, 1520 Avenue Pl #120 Atlanta, GA 30311
April 19, 2017	**Town Hall Meeting** CDC, Roybal Campus Building 19, Auditorium A
8:30 am - 9:00 am	**Opening and Introductions** Dr. Donna Hubbard McCree DHAP Associate Director for Health Equity Dr. Kirk D. Henny Behavioral Scientist, DHAP Meeting Co-Chairs HIV in the South Planning Committee Members **Welcome** Dr. Jonathan Mermin NCHHSTP Director Dr. Eugene McCray DHAP Division Director
9:00 am - 9:05 am	**Purpose of Meeting and Review of Agenda** Drs. McCree and Henny
9:10 am - 10:30 am	**Facilitated Group Discussion**

The Facilitators will guide the discussion with a purpose of soliciting individual feedback on the topic area.

Topic Area for Group Discussion
Facilitators: Drs. McCree and Henny

1. What are the key challenges in your states and/or jurisdictions to delivering HIV prevention and care services, i.e., HIV testing, linkage, reengagement and retention in care, behavioral and biomedical prevention interventions, etc., for gay and bisexual men, young black MSM, black women, Hispanic/Latino MSM and transgender persons?

10:30 am – 10:40 am **Break**

Topic Areas for Facilitated Round Table Discussions

2. What activities, e.g., innovative solutions, effective strategies, lessons learned, best practices, etc., have you utilized in your states and/or jurisdictions to address challenges for delivering HIV prevention services to the populations listed in question #1?

3. Given the activities that you utilized, describe the key partnerships and collaborations created to address the key challenges. What key partnerships and collaborations at the local, state, and federal level could be used to address HIV-related health disparities for the populations you serve?

Facilitators:
Group 1, Room 245: Ms. Andrea Moore, Mr. Lamont Scales and Mr. Justin Smith
Group 2, Room 246: Dr. Kim Williams and Dr. Erin Bradley
Group 3, Room 247: Dr. Euna August and Dr. Angelica Geter
Group 4, Room 248: Dr. Billy Jeffries and Dr. Ashley Lima

10:40 am – 12:10 pm **Facilitated Round Table Discussions**

12:15 pm – 1:00 pm **Lunch** (on your own)

1:00 pm – 2:30 pm **Facilitated Round Table Discussions** (continue)

2:30 pm – 2:40 pm **Break**

2:45 pm – 3:45 pm **DHAP Senior Leaders Panel – Ask the Leader**
Dr. Eugene McCray
Ms. Janet Cleveland
Dr. David Purcell
Dr. Elizabeth DiNenno

Facilitators: Mr. Reginald Carson, Ms. Laura Eastham, and Ms. Ijeoma Ihiasota

3:45pm – 4:00 pm **Next Steps and Acknowledgements**

	HIV in the South Planning Committee Members
4:00pm – 4:15pm	**Closing Remarks** Dr. Eugene McCray, DHAP Division Director Drs. McCree and Henny

Invited Participants

Roundtable Group #1

- Scott Rhodes, PhD – Wake Forest University
- Susan Reif, PhD – Duke University
- June Gibson, PhD – My Brother's Keeper, Mississippi
- Phill Wilson – Black AIDS Institute
- Lorraine Austin – Fulton County Department of Health and Wellness
- Jenny McFarlane – Texas Department of Health
- Kira Villamizar – Florida-Dade Department of Health
- Nic Carlisle, JD – Southern AIDS Coalition
- Virginia Caine, MD – National Medical Association
- Dea Varsovczky – Urban Coalition for HIV Prevention Services (UCHAPS)
- Nimaako Brown – National Urban League

Roundtable Group #2

- John Peterson, PhD – Georgia State University
- Wendy Armstrong, MD – Emory University School of Medicine
- Darwin Thompson – NAESM
- Mark Johnson – The Brotherhood, Incorporated, New Orleans
- James Stewart, PhD – Mississippi State Department of Health
- Ali Mansaray – South Carolina Department of Health and Environmental Control
- Joshua Rodriguez – Florida-Broward County Department of Health
- Arianna Inurritegui-Lint – TransLatina Coalition of Florida
- Rodriques Lambert, PhD – Georgia Department of Public Health
- Melissa Baker- National Black Leadership Commission on AIDS
- Bernice Frazier – Southern Christian Leadership Foundation
- Cleo Manago, PhD – Black Men's Xchange

Roundtable Group #3

- Carolyn McAllaster, JD – Duke University
- Sharon Decuir – HIV/AIDS Alliance for Region Two, Incorporated, Baton Rouge
- Mary Elizabeth Marr – THRIVE Alabama
- Jesse Milan – AIDS United
- Mara Michniewicz – Florida Department of Health
- Sharon Jordan – Alabama Department of Public Health
- L. William Lyons – Georgia Department of Public Health
- Erik Valera – Latino Commission on AIDS
- Jessica Fridge – Louisiana Department of Health
- Murray C. Penner – NASTAD
- Sharon Lettman-Hicks- National Black Justice Coalition
- Laurie Reid, RN – Atlanta Black Nurses Association
- Megan McLemore, JD – Human Rights Watch

Roundtable Group #4

- DeMarc Hickson, PhD – Jackson State University
- Carlos Del Rio, MD – Emory University School of Medicine
- Kathie Hiers – AIDS Alabama
- Kirk Myers – Abounding Prosperity, Dallas
- Sable Nelson, JD – Sister Love, Incorporated, Atlanta
- Melissa Morrison – Tennessee Department of Health
- John S. Furnari – North Carolina Department of Health and Human Services
- Nicholas Mosca, DDS – CresentCare, New Orleans
- Virginia Banks-Bright, MD – The Links, Incorporated
- Bambi Gaddist, DrPH – South Carolina HIV/AIDS Council

- Elena Rios, MD – National Hispanic Medical Association

Federal Partners

- Richard Wolitski, PhD – Office of HIV/AIDS and Infectious Disease Policy, Department of Health and Human Services
- Laura W. Cheever, MD – Health Resources and Services Administration
- Steven A. Young, MS – Health Resources and Services Administration
- Dianne Rausch, PhD – National Institute of Mental Health, The National Institutes of Health
- David W. Knight, JD – Department of Justice

HIV in the South Planning Committee Members

- Eugene McCray, MD - DHAP Director
- Donna Hubbard McCree, PhD, MPH, RPh - DHAP Associate Director for Health Equity (Co-Chair)
- Kirk D. Henny, PhD, MA - Epidemiology Branch (EB), Co-Chair
- Emilio German, MHS - DHAP Office of Health Equity (OHE)
- Lamont Scales, MS - DHAP OHE
- Reginald Carson - Prevention Program Branch (PPB)
- Andre Dailey, MSPH - HIV Incidence and Case Surveillance Branch (HICSB)
- Laura Eastham, MPH- Policy Team Lead, DHAP Office of the Director (DHAP OD)
- Ijeoma Ihiasota, MSPH – Policy Team, DHAP OD
- Carol Parks, PhD, MS - Capacity Building Branch (CBB)
- Betsy Gunnels, MS - Quantitative Statistics and Data Management Branch (QSDMB)
- Wade Ivy, PhD, MPH - Behavioral and Clinical Surveillance Branch (BCSB)
- Andrea Moore, MS - Program Evaluation Branch (PEB)
- Kim Williams, PhD, MSW - Prevention Research Branch (PRB)
- William L. Jeffries IV, PhD, MS, MA - Capacity Building Branch (CBB)
- Ann O’Leary, PhD - Prevention Research Branch (PRB)
- Euna August, PhD, MPH - Prevention Communication Branch (PCB)
- Joynecia Clements - Prevention Communication Branch (PCB)
- Erin Bradley, PhD, MPH - HIV Prevention in Communities of Color Postdoctoral Fellow, EB
- Angelica Geter, DrPh, MPH -HIV Prevention in Communities of Color Postdoctoral Fellow, EB
- Ashley Lima, PhD, MPH - HIV Prevention in Communities of Color Postdoctoral Fellow, CBB
- Justin C. Smith, MPH - ORISE Fellow, DHAP OHE

Collaborators

- Jo Valentine, MSW – Division of STD Prevention
- Richard Dunville, MPH – Division of Adolescent and School Health