


Implementing the Trump Administration's "Ending the HIV Epidemic" Plan in the Southern United States

 See also Kapadia and Landers, p. 15; and the *AJPH* Ending the HIV Epidemic section, pp. 22–68.

I have been working in the HIV arena for about 25 years, and what a wild ride it's been! I vividly remember the horrible, early days of the epidemic, when an HIV diagnosis was a death sentence. We could do little more than help folks die with some dignity intact. I lost many dear, brilliant friends who didn't live to see the enormous scientific strides we have taken.

In 1996, effective medication became widely used, and we saw the death rates plummet. The drugs were far from perfect, however, with many terrible side effects, an unbelievable number of pills required, and an equally daunting price. As the years progressed, these difficult medications became better and better, and the pill burden was dramatically reduced.

Fast forward to today: we have tests that can detect a new infection in a minute and screenings that can reveal acute infections, meaning recent transmission. We have effective medications with better durability and fewer side effects. Many regimens consist of one pill once a day, and we are excited about the highly anticipated long-acting treatment options. We have medications that can prevent a person from getting HIV. We

understand the medical protocol that allows HIV-positive women to have HIV-negative babies. The life span for a person living with HIV is now within five years of the national average life span. Most surprising of all, we have discovered that a person living with HIV who is on treatment and who has a suppressed viral load (meaning very little HIV in the blood) cannot transmit the virus to others! This new scientific information is a real game changer. Persons living with HIV can now have long, healthy, normal lives, as well as active sexual lives. The campaign Undetectable = Untransmittable has taken off around the country and the world. We have maps that capture community viral load numbers so that resources can be targeted to areas in need.

Now the Trump administration has committed to a 10-year initiative—Ending the HIV Epidemic: A Plan for America—which includes new federal resources to implement the plan. I am pleased that the plan includes many Southern and rural areas, but I am equally dismayed that the plan is almost completely medical, with little emphasis on mechanisms to address other factors that

keep people from staying in and adhering to treatment.

The Centers for Disease Control and Prevention estimates that 90% of new HIV infections are transmitted by people who are not diagnosed or are not in care.¹ Thus, our task seems clear: increase testing and get people into treatment. Why is that task so difficult, especially in the Southern United States? I see my colleagues in San Francisco, California, and New York City making real progress toward the goal of reducing the new cases to levels below the epidemic thresholds, yet the South lags behind.

I often say that the South presents the perfect storm for the HIV epidemic. In so many ways the South is far below national averages on structural factors that affect public health: poor access to medical care and health insurance, health disparities in every disease state or indicator, lack of decent transportation systems, pervasive poverty, poor educational systems that often ignore sexual health, vast rural areas that

make health care more complicated and costly, the country's largest disenfranchised minority populations who often deal with structural racism, and a huge dose of stigma that serves as the icing on this unhealthy cake.

From the beginning, the HIV epidemic has been fueled by ignorance and stigma, including laws that punish people for being HIV positive, even if they are doing everything right. Politicians were afraid to even say the word *AIDS*. In the South this barrier is rampant and is often exacerbated by conservative religious beliefs and elected policymakers. People are afraid to go to local health departments, where someone might know them; gay men pretend to be heterosexual to avoid condemnation; and some churches even demonize this disease, despite the fact that their congregations are affected.

The problem of stigma is hurting the South. We are now the epicenter of the country's HIV epidemic. In addition to the highest rates of diagnoses, the South sees the highest death rates in the country from a disease that can now be managed. In 2016 the Deep South states, defined as Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Texas, experienced 6045 deaths, 39% of the nation's total deaths from HIV. From

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2008 through 2016, Alabama, Louisiana, and Mississippi saw the highest death rates of persons living with HIV.²

I hope that the architects of this new, ambitious government plan to end HIV as an epidemic will think beyond our status quo parameters. New funding needs to go directly to community providers, bypassing the typical bureaucratic barriers encountered in current service delivery systems. In addition to treatment, focus must be placed on peer support programs, housing, food, transportation, mental health and substance use services, intimate partner violence, employment services, challenges of aging with HIV, and any other roadblocks that keep patients out of care. Many of the people we serve in the HIV community have experienced trauma, and we need providers who understand that lived experience and can provide culturally appropriate services that combat stigma.

The plan promotes four pillars—diagnose, treat, prevent, respond—which include expansion of pre-exposure prophylaxis (PrEP). Many small to medium-sized cities in the South have no medical providers willing to prescribe PrEP. Some of the funding might be well spent in helping trusted community organizations develop clinics for PrEP, sexually transmitted infections, and hepatitis C. The need to build infrastructure to deliver these services in the US South may be a critical component in the success of the plan. Essential to the plan's success is maintaining the current funding in the country's HIV portfolio and layering the new funding onto the good programs already in place.

I have heard about a time when cancer was met with suspicion and fear. I remember

when women were condemned for taking birth control pills. I know that one day we will look back on the HIV epidemic with the same puzzlement. How did a disease become so vilified? The time has come to move HIV from the moral arena to the medical arena, including critical social services and housing. This approach will allow supportive communities in the Southern United States to fully use the exciting scientific progress that has been made in our fight to end HIV as barriers to staying adherent and in care are removed. If we have real hopes of ending HIV as an epidemic, a holistic approach that includes the Southern United States is our best chance for success. **AJPH**

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CONFLICTS OF INTEREST

The author has no conflicts of interest to declare.

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