

Chapter 2

More than Our Share: The Unchecked HIV/AIDS Crisis in Mississippi

Susan Hrostowski

Introduction

Rich and varied cultures as well as rich and varied geography make Mississippi a charming state. Mississippi has provided the world with talented musicians, gifted authors, and many creative individuals who have shaped American culture. There is beauty in the century-old oaks trees, power in the mighty Mississippi River, excitement in the sun and sand of the gulf coast, and grace in the abundance of fragrant azalea bushes. Underneath the veneer of southern gentility and beauty, however, there is a tangled and disparaging world of hardship and disparity. There are layers of dark history that have left deep gouges in the metaphorical landscape and continue to impact much of everyday life for the residents of the state. The horrors of slavery and segregation still echo throughout Mississippi, and prevailing conservative Christian values have profound effects on social welfare policy. Meanwhile, modern societal problems such as extreme poverty, racism, and sub-standard education tear at the fabric of Mississippi society. Mississippi's place as last in the country in almost every socioeconomic category causes and exacerbates a host of deeper issues, and chief among them is the HIV/AIDS crisis, one of Mississippi's deadliest and yet most ignored problems.

S. Hrostowski (✉)

Social Work, The University of Southern Mississippi, 118 College Drive #5114,
Hattiesburg, MS 39406, USA

e-mail: susan.hrostowski@usm.edu

Barriers to Curbing HIV in Mississippi

According to Reif, Geonnotti, and Whetten, (2006), factors that contribute to the spread of the HIV/AIDS epidemic in the South include stigma, conservatism, high rates of STIs, disparity, and poverty. Poor health literacy and poor education contribute to the stigma surrounding HIV and AIDS (Rosenberg, Broad, Mehlsak, Clark, & Greenwald, 2010). Many Mississippians including people with HIV do not know the facts about the disease, its causes, its modes of transmission, or its treatments. Stigma prevents people from getting tested and from getting treated, and results in discrimination against people who are infected with HIV. Research shows that

Lack of knowledge about one's serostatus may in turn lead to inadvertent transmission of the virus and delays in the initiation of treatment. Second, among those who have been tested and are HIV-positive, stigma constitutes a chronic stressor that may contribute to coping difficulties, inadequate self-care, and difficulties with safer sex negotiation and condom use. (Venable, Carey, Blair, & Littlewood, 2006, p. 473).

Mississippi's political and social conservatism precludes helpful legislation. From the beginning of the AIDS crisis, Mississippi's government has been reluctant (and sometimes adamantly opposed) to providing education, prevention, services, or care. The political and social atmosphere in Mississippi has long reaching consequences with conservative views leading to resistance in creating or funding services for people with HIV/AIDS. Proposals to establish and maintain two HIV/STD clinics; to fund education, prevention, and treatment services; to remove the prescription drug and testing limits Medicaid has for HIV; and to match funds provided by the Ryan White Care Act all died in committees of the Mississippi Legislature (H.B. 326, 2013; H.B. 343, 2013; H.B. 1321, 2003; H.B. 169, 1998). Stigma around HIV/AIDS is perpetuated by laws that make it a crime to expose others to HIV/AIDS. In Mississippi, it is a federal offense to expose another person to HIV knowingly. This includes spitting and biting, which have been proven to not be exposure risks (Miss. Code Ann. § 97-27-14(1)).

The stigma of homosexuality in Mississippi is currently being exacerbated by the passage of Mississippi House Bill 1523, "Protecting Freedom of Conscience from Government Discrimination Act" which defines marriage as the union of one man and one woman and also classifies sex as only appropriate in the confines of that specific definition of marriage. It also stipulates that counselors may refuse to provide services to lesbian, gay, bisexual, and transgender clients (H.B. 1523, 2016). The bill was signed into law by the governor and was to go into effect on July 1, 2016, but was enjoined by the sixth district court. The governor has appealed this injunction, and that appeal is pending in the Fifth District Court of Appeals at this time. When accepting an award from an anti-LGBT rights group, he said that Christians will "stand in line to be crucified" for this law (Villarreal, 2016).

Public schools in Mississippi are required to teach abstinence-only or abstinence-plus sex education (H.B. 999). Both curricula teach that sex within the confines of marriage is the best way to prevent unplanned pregnancies and sexually transmitted diseases, but neither curriculum teaches safe sex practices such as

condom usage. Not surprisingly, Mississippi ranked third in the country in the rate of teenage pregnancy in 2014, with the rate being 55% higher than the national average and more than 250% higher than the state with the lowest teen pregnancy rate, Massachusetts (The National Campaign to Prevent Teen and Unwanted Pregnancy, 2016). Sexually transmitted diseases also ravage Mississippi. Ranking twelfth for syphilis, third gonorrhea, and fifth for chlamydia demonstrates the critical need for improved sex education and removal of barriers for prevention in Mississippi. STDs not only predict HIV infection but actually promote it by lowering the immune system during active STD infection (CDC, 2016). Clearly, more comprehensive sex education is needed, considering these high rates and the fact that nationwide one in four new HIV infections are among young adults aged 13–24.

Racial disparity plays a significant role in Mississippi's HIV/AIDS crisis, and the high rates of new infections are most prominent among African Americans. Although African Americans make up only 37.6% of Mississippi's population (QuickFacts Mississippi, 2015), 78% of all new infections are among African Americans (MS Department of Health, 2015), nine times the rate of white individuals. African Americans are also ten times more likely to die than White HIV-positive individuals (MS Department of Health, 2010). The reasons for this racial discrepancy are the same seen in other areas of health disparity: poverty, lack of education, and poor general health. Additionally, the stigma surrounding sexual orientation and HIV status is stronger in the African American community, compounding the stigma and the barriers to care it presents noted above.

Chief among the challenges in combatting HIV is Mississippi's poverty. With 21.5% of adults and 35% of children living below the federal poverty line, Mississippi is the poorest state in the union (QuickFacts Mississippi, 2015). Poverty, of course, means a lack of basic resources and a lack of access to resources. The lack of transportation is a significant problem for people in poverty and makes access to health care and other resources extremely difficult.

Mississippi's Unique Challenges

HIV infection rates in Mississippi are among the highest in the country. According to the CDC, "The lifetime risk of HIV diagnosis is highest in the District of Columbia, followed by Maryland, Georgia, Florida, Louisiana, New York, Texas, New Jersey, Mississippi, South Carolina, North Carolina, Delaware, and Alabama" (HIV and AIDS in the United States by Geographic Distribution). It is important to remember that African Americans in Mississippi are disproportionately affected with more than eight times the rate of infection as Whites. The capital city of Jackson has the fourth highest rate of new infections in the country and the highest rate in the country among black men who have sex with men (CDC, 2014). Mississippi as a whole ranks second in the rate of new infections among 13–24 year

olds. Compared to all the other states in the union, Mississippi has twice the national rate of death from HIV/AIDS (AIDSvu, 2016). Lack of testing due to stigma and lack of linkage to care both contribute to these high rates. According to Dr. Leandro Mena with the University of Mississippi Medical Center, half of all Mississippians diagnosed as HIV-positive are not receiving treatment (Fowler, 2016). In the more rural areas, people may not have access to care.

In this environment, people who test positive for HIV and the agencies who serve them scramble for resources. In a study of 218 HIV-positive persons utilizing a Ryan White clinic through a rural health association, the participants identified their most pressing needs as housing, financial assistance to meet basic needs, education about HIV medications, transportation, and assistance with medications other than their HIV medications (Hrostowski & Camp, 2015). Many need assistance in purchasing psychotropic medications and medications for such conditions as diabetes, high blood pressure, and heart disease; all of which affect their HIV treatment.

Safe and secure housing is vital to the health and well-being of anyone, and especially to those who are HIV-positive. Homelessness has been correlated with an increased risk of HIV, and homeless people with HIV/AIDS experience a worsening of symptoms three to six times the rate of individuals with HIV/AIDS with stable housing (National Health Care for the Homeless, 2008). This is likely due to reduced access to care, which leads to higher rates of morbidity, hospitalization, and mortality (Reid, Vittinghoff, & Kushel, 2008). Kathryn Garner, Executive Director of AIDS Services Coalition in Hattiesburg says, "Housing is treatment, and those who do not have it are at a much greater risk of dying. It's almost impossible to stay in care if you don't have a place to live" (Garner, personal communication, 2016).

One program that addresses housing needs is Housing Opportunities for People with AIDS (HOPWA). Funded through the U.S. Department of Housing and Urban Development, HOPWA provides case management, housing assistance, and other supportive services to low-income individuals living with HIV/AIDS. The problem here is the formulary used to allocate funds to the states. The formula used by HOPWA is based on the total number of HIV/AIDS cases in each state from the beginning of the outbreak of the virus, and those who have died are also included. Southern states would be allocated much more money if the HOPWA formula provided funds to the states based on the number of individuals actually living with HIV/AIDS (Hrostowski & Camp, 2015). Without this support, many people living with HIV are homeless or living in unstable situations.

HIV medications are provided to many patients through Ryan White funding. But again, the formulary short-shifts Mississippians. In Fiscal Year 2013, the Deep South received an average of \$3111 per AIDS case, while the national average excluding these states was \$3843. This inequity has grown smaller over the last decade but the formula used for the disbursement of Ryan White funds is based on the total number of HIV infections instead of the number of new infections (Southern AIDS Coalition, 2012). Also, the formula does not take into account factors such as rural areas lacking medical providers or the cost of transportation for

individuals living in rural areas to travel to medical providers in other areas (Hrostowski & Camp, 2015).

Because the majority of new infections are among people in poverty, the majority (51%) of payments for medical care for Mississippians with HIV/AIDS comes from Medicaid. Had Mississippi chosen to expand Medicaid under the Affordable Care Act, many more people living with HIV would have had access to care. In fact, 89% of Mississippians with HIV/AIDS whose services are paid through Ryan White funds would have become eligible for Medicaid. Mississippi, however, refused to expand Medicaid, as did many other southern states (H.B. 285, 2013; Center for Health Law and Policy, 2013). Again viewing Mississippi through the lens of the southeastern region of the United States, Medicaid enrollment of individuals with HIV/AIDS reveals a disparity. The national average of enrollment is 26%, but enrollment in the South is 23%. Getting Medicaid coverage in the South is more difficult than in other states due to more limiting eligibility criteria for adults with dependent children. Furthermore, even when people living with HIV or AIDS in the South have Medicaid, Medicaid will often limit the number of prescriptions covered, which can greatly affect a person who is already ill and living in poverty (Kaiser Family Foundation, 2011). Although the federal government pays Mississippi \$3 for every \$1 spent, Mississippi spends much less per individual than average for the nation. Specifically, the national average spent is a thousand dollars more per individual than what Mississippi spends, although Mississippi is receiving federal funds at the highest possible level (Human Rights Watch, 2011). Mississippi's income maximum for Medicaid eligibility is 46% of the federal poverty level, but the national cap is 66%.

As noted earlier, the lack of transportation is a problem for many Mississippians. Public transportation is only available in the larger cities, and even in those cities it is often limited. The SHARP report for Mississippi states

In poor, rural areas, many residents do not have cars. Even if households have a vehicle, family members may have to share access to it, and may not be able to afford gas, maintenance, or insurance costs. Cars may be unreliable over long distances, such as highway travel; because of the rural nature of Mississippi, the nearest provider might be far away (Rosenberg et al., 2010, p. 57).

Advocates and Champions

In spite of the seemingly insurmountable problems and barriers to preventing HIV infection and helping people who are infected with or affected by HIV, Mississippi does have its HIV advocates and champions. In addition to the governmental agencies, such as the Department of Health, there are a few private, nonprofit AIDS service organizations (ASO's). As of this writing, there are four functioning ASO's in Mississippi. My Brother's Keeper (MBK) serves people in the Jackson metropolitan area and the Mississippi Gulf Coast, Grace House is also in Jackson,



Fig. 2.1 MBK serves people in the Jackson metropolitan area and the Mississippi Gulf Coast

AIDS Services Coalition (ASC) is located in Hattiesburg and serves the mid-south region of the state, and the Southern AIDS Coalition (SAC) serves the Mississippi Delta. See Fig. 2.1. An ASO on the Mississippi Gulf Coast recently closed its doors due to financial difficulties. Telehealth services, in filling these service gaps, are a part of the Mississippi Department of Health's Statewide Comprehensive HIV Plan, but have yet to be implemented (MDH, 2012a, b).

The executive directors of these organizations spend a disproportionate amount of their time searching for funding to stay open and resources to serve their clients. Kathryn Garner of ASC states, "In other states, non-clinical agencies that provide supportive services to persons living with HIV share in Ryan White funding or in state-allocated funding. The Mississippi Legislature barely funds the required match each year, so funding for all but the medical and medication basics is but a wish"

(Garner, personal communication, 2016). In the last 2 years, two of the five ASO's in Mississippi have closed their doors. One of these agencies provided vital nutrition and supportive services in Jackson—where HIV rates for African American gay males by 2020 are expected to show that one in two are infected. The other was one of only three in Mississippi providing housing. Resources such as mental health care, treatment for addictions, transportation, housing, and employment opportunities are often limited and difficult to access.

SHARP participants report a fragmented community structure and comment that cooperation and collaboration among ASOs, CBOs, and other providers is limited. This is probably due, at least in part, to competition for very limited resources. Compounding the issue is the fact that Mississippi has very few ASOs—some parts of the state, like northeast Mississippi, have no ASOs. There are very few “one-stop” ASOs that provide prevention education and testing, as well as supportive services like case management. There has also not been a consistent, statewide HIV/AIDS grassroots advocacy network, again probably at least partly due to a lack of resources (Rosenberg et al., 2010, p. 53).

Outlook

Unfortunately, resources are becoming even scarcer at this writing. Mississippi's state budget is in crisis. The State of Mississippi's 2017 budget has been drastically reduced from previous years due to revenue shortfalls and new tax cuts for businesses (Pender, 2016). Because of the cuts in state funding, Mississippi will lose even more in federal funds, because the state cannot meet the match requirement. Most departments will see sizeable funding cuts, leading to reductions in staff and services. The Department of Health is cutting at least 64 medical professionals from its staff and substantially reducing the services it renders to communities. In light of its 4.4% or \$8.3 million-dollar budget cut, the Department of Mental Health will decrease the number of available psychiatric beds by more than 30 and the number of substance abuse treatment beds by about 67. There will no longer be a state-operated male chemical dependency unit in the state (Gates, 2016). These cuts along with the dismantling of the vocational rehabilitation services directly affect people with HIV/AIDS who rely on these departments for essential services.

Dr. Thomas Dobbs, the state epidemiologist, said in an interview that Mississippi's government has not considered the broader effects of its policies.

Because we don't fund public health, we are a slave to federal programs and can't use the money we get from them in creative ways that meet the unique needs of Mississippians. The real tragedy in the systematic destruction of the public health system that can't respond to usual health concerns, let alone outbreaks of diseases. This makes it impossible to plan for the future (Dobbs, personal communication, 2016).

Dr. Dobbs went on to say that because of governmental antipathy, the local infrastructures are so limited that they cannot implement new interventions effectively, making responses to HIV less than optimal. Because Mississippi is not

participating in the ACA, options for funding are limited. More outreach is needed to address the HIV epidemic, but the staff and the structures are not in place to carry it out.

Conclusion

The current situation and the foreseeable future are grim for Mississippians battling HIV, for people who are infected with or affected by HIV, for patients, families, friends, and service providers. Without fundamental changes in the values and mores, in the culture, of the people of Mississippi, changes in the state's approach to HIV will not occur. Homophobia, racism, and ignorance exacerbate the crisis. Policies created by legislators with these mindsets restrict the dissemination of prevention and treatment information, discourage people from getting tested, and inhibit the delivery of services.

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