Final Report

Toward a More Responsive HIV Response

Community Priorities and Public Health Partnership in the South

Southern CBO Meet & Greet

Prepared by NACCHO in partnership with the Southern AIDS Coalition

May 2026

Acknowledgements

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Executive Summary

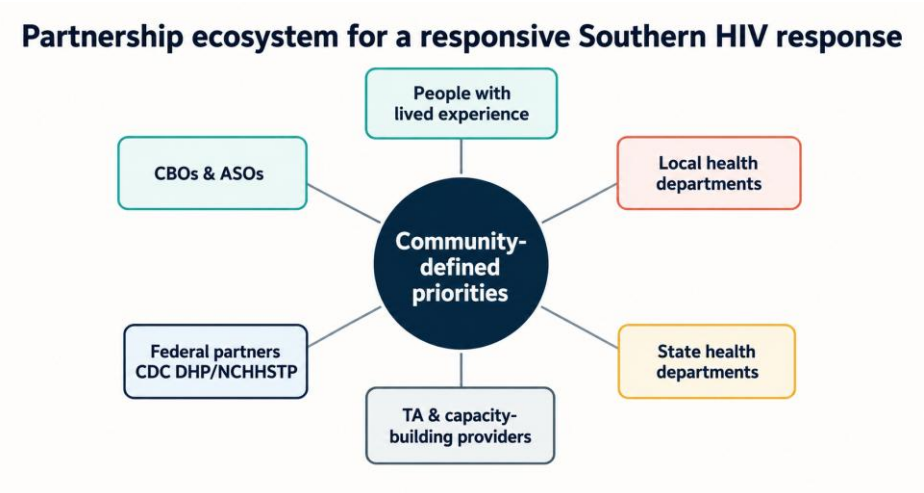
The Southern CBO Meet & Greet series was a partnership-building initiative designed to strengthen communication, trust, and alignment among community-based organizations, local and state public health departments, and federal partners in six Southern Ending the HIV Epidemic priority jurisdictions: Atlanta, Jackson, Houston, Baton Rouge, Memphis, and Miami.

Across jurisdictions, community stakeholders identified a consistent set of priorities: flexible and equitable funding, stronger collaboration infrastructure, representative leadership and workforce development, affirming HIV messaging, trust-building, and whole-person approaches that address housing, transportation, mental health, violence, stigma, and other non-medical drivers of health.

These realities reinforce the need to move beyond narrowly focused HIV programming and toward whole-person strategies that address the interconnected social, structural, and health-related challenges communities face every day. By applying a syndemic lens, local health departments, CBOs, and federal partners can better align resources, reduce service fragmentation, and design interventions that reflect the lived experiences of Southern communities. This approach positions HIV prevention and care as part of a broader strategy—one that recognizes community-defined priorities, strengthens trust, and creates more responsive systems of support.

Report at a glance

- Six Southern EHE priority jurisdictions engaged through community-centered conversations.
- A two-day report-out meeting connected community findings to state and local health department practice.
- The 15% Solution activity helped participants identify immediate, feasible steps within their control.
- Findings point toward more flexible funding, stronger workforce investment, reciprocal engagement, and whole-person care.



Purpose and Context

The HIV epidemic in the United States continues to be marked by deep geographic and demographic contrasts, with the Southern region carrying a disproportionate share of the burden. In 2022, more than half of all new HIV diagnoses in the U.S. occurred in the South, despite the region accounting for only about 38% of the national population. Structural factors—including poverty, stigma, limited access to prevention and care, gaps in insurance coverage, and other persistent barriers—continue to drive these differences in outcomes, and undermine progress toward federal goals articulated through the Ending the HIV Epidemic in the U.S. (EHE) initiative and related national strategies.

Against this backdrop, the National Association of County and City Health Officials (NACCHO) partnered with the Southern AIDS Coalition in June 2023 to strengthen partnerships between local community based organizations (CBOs), local and state public health departments, and federal partners in the CDC Division of HIV Prevention (DHP) and other offices within the National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP). The initiative was intentionally designed as a partnership-building effort rather than a traditional programmatic intervention, with the goal of improving communication, mutual accountability, and alignment between community organizations, health departments, and federal agencies in high-burden jurisdictions.

Beginning in 2023, NACCHO and SAC launched a series of in-person convenings in six EHE priority jurisdictions: Atlanta, Georgia; Jackson, Mississippi; Houston, Texas; Baton Rouge, Louisiana; Memphis, Tennessee; and Miami, Florida. These sites were selected because they reflect some of the highest HIV burdens in the country, layered with extensive social and structural vulnerability, but also strong networks of CBOs and AIDS service organizations (ASOs). Together, they represent a diverse cross-section of the Southern epidemic—from large urban centers to state capitals and mid-sized metropolitan areas—making them ideal for exploring how community–government partnerships can be strengthened in practice.

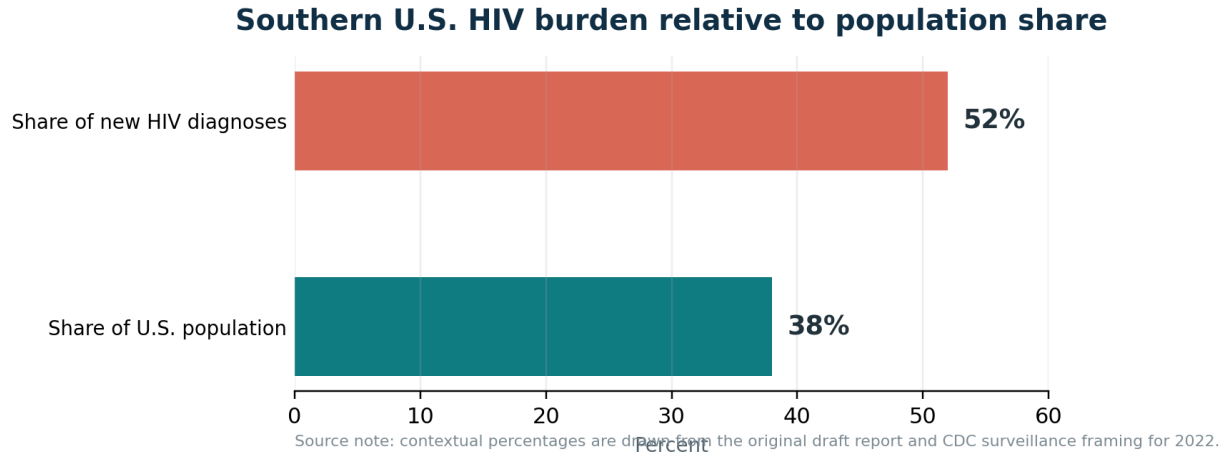


Figure 2. The Southern U.S. carries a disproportionate share of new HIV diagnoses relative to its share of the national population.

Southern Convening Sites

Beginning in 2023, NACCHO and SAC launched a series of in-person convenings in six EHE priority jurisdictions. The sites were selected because they reflect high HIV burden, social and structural vulnerability, and strong community networks that are critical to local HIV prevention and care responses.

Figure 3. Convening sites included Atlanta, Jackson, Houston, Baton Rouge, Memphis, and Miami.

Each jurisdiction illustrates a distinct but interconnected set of challenges:

Atlanta, Georgia

Georgia remains among the states with the highest HIV burden in the country. State surveillance data show that, in 2022, 2,575 people were newly diagnosed with HIV (24 per 100,000 population), and new diagnoses remain heavily concentrated in the Atlanta metropolitan area. Atlanta's 20-county metro area has been ranked among the top U.S. metropolitan areas for rates of new HIV diagnoses; Black residents account for roughly one-third of Atlanta's population but also represent a large majority of the people newly diagnosed with HIV and living with HIV reflecting the longstanding inequities in housing, employment, access to healthcare, and exposure to stigma they experience

Jackson, Mississippi

Jackson and surrounding Hinds County sit at the center of one of the most challenging HIV and STI landscapes in the United States. Mississippi has been identified as a state with some of the highest rates of sexually transmitted infections, and recent analyses describe it as having one of the most severe STI crises nationally. Local media and health data highlight that the state's HIV prevalence is high, on the order of several hundred cases per 100,000 residents, with Hinds County consistently among the top counties for new HIV diagnoses and other STIs. These conditions reflect entrenched poverty, and limited access to clinical services comprehensive sexual health services and education, making Jackson a critical site for rethinking community engagement and equitable resource allocation.

Houston, Texas (Harris County)

The Houston Eligible Metropolitan Area (EMA), which includes Harris County, continues to see substantial HIV transmission. In 2022, 1,413 new HIV diagnoses were reported in the Houston EMA, a 5% increase from 2021, with more than 33,000 people living with HIV by the end of that year. Harris County consistently reports HIV rates above the Texas average, and new diagnoses are concentrated among young adults and Black and multiracial communities, particularly in neighborhoods with a legacy of redlining and underinvestment. This combination of high burden and pronounced differences in opportunity and access to resources underscores the importance of strong, trust-based partnerships between health departments and community organizations.

Baton Rouge, Louisiana

Louisiana has ranked near the top nationally for HIV diagnosis rates; in 2022, the state's diagnosis rate was approximately 18–19 per 100,000 population, placing it fourth among U.S. states. Within the state, the Baton Rouge metropolitan statistical area (MSA) is consistently ranked among the highest large metropolitan areas for HIV case rates (around 18.4 per 100,000) reflecting intense local transmission. High HIV and STI rates in Baton Rouge intersect with concentrated poverty, under-resourced safety-net services, and uneven access to prevention tools such as PrEP, making it a key site for examining how public agencies and CBOs collaborate, share power, and sustain community-driven strategies.

Memphis, Tennessee (Shelby County)

Memphis and Shelby County have long been recognized as a hotspot in the Southern HIV epidemic. Community and media reports note that Shelby County has the highest number of people living with HIV of any county in Tennessee, with teens and young adults carrying particularly high infection rates. Earlier epidemiologic analyses have documented HIV diagnosis rates among youth and young adults that are several times higher than national averages, with the majority of new diagnoses among Black residents. These data highlight the need for youth-focused, culturally grounded prevention approaches that are co-developed with communities, rather than imposed from above.

Miami, Florida (Miami-Dade County)

Miami-Dade County continues to bear one of the heaviest HIV burdens in the country. Recent EHE indicator data estimate roughly 770 new HIV infections in 2022, translating into an incidence rate well above both state and national averages. Miami-Dade also shows pronounced

disparities in HIV diagnosis, care, and viral suppression outcomes, alongside persistent gaps in PrEP coverage. These patterns, make Miami a critical jurisdiction for testing more fair, community-responsive models of partnership between local, state, and federal stakeholders.

The Meetings

Across the six jurisdictions, the convenings brought together CBOs, ASOs, organizations working on social determinants of health, local and state health department staff, and representatives from CDC's DHP and other NCHHSTP offices. The meetings provided federal partners, including CDC's Community Engagement and Strategic Partnerships staff with an opportunity to hear directly from community stakeholders about barriers to meaningful engagement, challenges in existing funding and reporting structures, and examples of effective local collaboration.

Feedback gathered across the six convenings was synthesized to identify recurring challenges, local priorities, and practical recommendations for strengthening relationships between CBOs, public health systems, and other institutional partners. Across jurisdictions, participants were asked not only to identify barriers, but also to articulate what would be needed for communities to flourish and what actions could be taken immediately to improve local HIV-related outcomes. This solution-oriented framing helped move discussion beyond problem identification alone and surfaced concrete, community-generated ideas for strengthening local ecosystems of prevention, care, and support.

Figure 4. The engagement process connected community listening, immediate-action planning, and health department report-back.

Jurisdiction-Level Findings

The following summaries preserve the full narrative content of the original draft report and describe the dominant themes raised by participants in each jurisdiction.

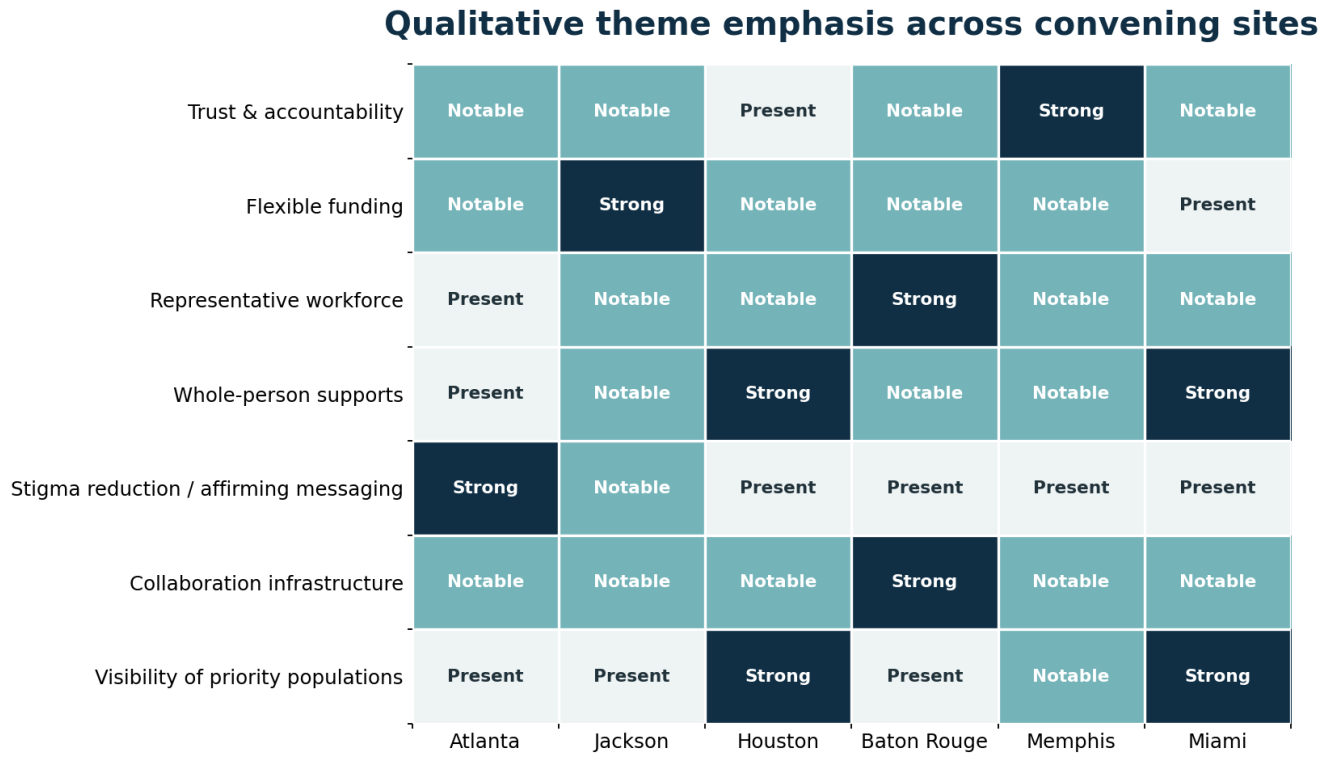


Figure 5. Qualitative theme emphasis across jurisdictions, based on narrative synthesis rather than quantitative survey counts.

Atlanta, Georgia

Feedback from Atlanta reflected both the strengths and tensions within a comparatively well-resourced but fragmented HIV landscape. Participants identified several assets already present in the local ecosystem, including strong interpersonal commitment, a willingness to share knowledge, and existing partnerships that can serve as a foundation for deeper collaboration. Community members acknowledged that there are individuals and organizations doing meaningful work and that there is no shortage of passion or expertise. At the same time, respondents emphasized that these assets are often undermined by siloed relationships, inconsistent outreach, and uneven access to resources.

A dominant theme in Atlanta was the need to improve how information, services, and opportunities are communicated to the community. Participants noted that outreach must be more intentional, visible, and accessible, particularly for people who may not already be connected to traditional HIV service networks. They also called for stronger partnerships that move beyond transactional collaboration and instead foster genuine coordination, shared planning, and mutual accountability. In addition, participants highlighted the need for sex education and HIV messaging that is current, affirming, and grounded in lived realities rather than fear, shame, or outdated assumptions.

Atlanta respondents were especially clear about the ways stigma continues to shape the local HIV response. Shame, silence, and judgment were described as enduring barriers that affect not only people seeking care but also the willingness of institutions to communicate openly and effectively. Participants also raised concerns about funding structures that can be rigid, exclusionary, or difficult for smaller and newer organizations to navigate. Taken together, Atlanta's feedback suggests that while the local response benefits from a strong base of community leadership and organizational activity, meaningful progress will require better coordination, more affirming public health messaging, and funding processes that are fair to all applicants and responsive to grassroots realities.

Jackson, Mississippi

Feedback from Jackson reflected the urgency of working within a resource-constrained environment where trust, representation, and institutional responsiveness remain central concerns. Participants focused heavily on what is missing from the current HIV response and what is needed to create the conditions for communities to flourish. A recurring theme was the need for stronger leadership and better training across systems. Respondents emphasized the importance of certified training opportunities, knowledgeable leadership, and greater accountability among those responsible for making decisions that affect community health.

Cultural sensitivity and representation were also central to Jackson's feedback. Participants stressed the need for leadership, providers, and frontline staff who understand the lived experiences, language, and social realities of the communities most impacted by HIV. This reflected a broader concern that many systems remain disconnected from the people they are meant to serve. Community members also pointed to persistent funding limitations, particularly for organizations that are deeply rooted in the community but may lack the administrative infrastructure or institutional relationships needed to compete for traditional funding opportunities.

Importantly, Jackson participants paired these structural concerns with practical ideas for action. Recommendations included more intentional resource sharing across organizations, collaboration instead of competition, improved outreach strategies tailored to specific communities, and language and cultural competency training for providers and staff. Participants also proposed reimagining traditional awareness activities, such as World AIDS Day, in ways that feel more relevant, inclusive, and locally meaningful. The emphasis on fun, affirming, and engaging community events further suggested that respondents view HIV work not only as a clinical or administrative issue, but also as a relational and cultural one. Overall, Jackson's feedback highlights the need for both institutional reform and community-driven strategies that make HIV prevention and care more visible, representative of affected populations, and grounded in local context.

Houston, Texas

In Houston, feedback centered on the need for greater visibility, stronger support systems, and more responsive infrastructure to meet the needs of communities disproportionately affected by HIV. Participants generated a range of practical ideas aimed at improving engagement and expanding access to support. Among the recommendations were normalizing HIV testing as routine practice, increasing the use of social media to reach communities more effectively, and

developing support groups that allow community members to learn from one another and build collective resilience.

Houston respondents also placed significant emphasis on mental health and whole-person support. Suggestions such as in-home therapy and peer-based support spaces reflected an understanding that access barriers are not limited to clinical services alone. Transportation, privacy concerns, stigma, and the emotional burden of navigating care systems all shape whether individuals can meaningfully engage in services. Participants also proposed the development of a Black caucus or similar structure to ensure that all communities affected by HIV receive sustained visibility, investment, and leadership space within the local HIV response.

Beyond immediate programmatic ideas, Houston feedback revealed broader frustrations with inflexible systems. Participants described the need for more adaptable funding, stronger policy protections, enhanced capacity-building for smaller organizations, and more effective collaboration across agencies. Transportation was also identified as a practical and persistent barrier to care. Houston's feedback points to a local response environment where communities have clear ideas about what is needed, but where implementation is often limited by structural constraints, uneven investment, and insufficient support for grassroots leadership.

Baton Rouge, Louisiana

Baton Rouge participants described a local environment in which gatekeeping, limited collaboration, and concerns about trust continue to impede progress. One of the strongest themes to emerge was the perception that access to information, influence, and resources is often controlled by a relatively small set of actors, creating barriers for broader community participation. Participants expressed a desire for a more open and collaborative ecosystem in which organizations can share knowledge, build relationships, and work collectively toward community goals rather than operating in isolation or competition.

Trust and organizational culture were also central concerns in Baton Rouge. Community members emphasized the importance of hiring people who are sensitive, empathetic, and capable of maintaining confidentiality. This feedback suggests that for many participants, the quality of relationships and the emotional safety of service environments are as important as the availability of services themselves. Respondents also called for more educational opportunities across the board, not only for community members but also for staff, leaders, and institutions engaged in HIV-related work.

Another notable theme was the need for dynamic and accesible funding. Participants expressed frustration with funding structures that do not adequately support a broad range of organizations or allow communities to respond flexibly to evolving needs. They also emphasized the importance of hiring and fairly compensating people with lived experience, suggesting that lived expertise should be valued not as symbolic input, but as essential workforce capacity. Baton Rouge feedback also pointed to a need for more grace and humanity in how systems engage clients, particularly those who face multiple barriers to care and are too often labeled as difficult or noncompliant. Overall, Baton Rouge participants described a local response that would benefit from greater openness, stronger relational trust, and a fair distribution of resources and leadership opportunities.

Memphis, Tennessee

Feedback from Memphis underscored the interconnectedness of HIV outcomes, civic engagement, workforce development, and community trust. Participants highlighted the importance of provider education, representative staffing, and meaningful collaboration as core components of an effective local response. A strong message emerged that systems work better when the people designing and delivering services reflect the communities most affected. Respondents called for hiring practices that prioritize local knowledge, shared lived experience, and cultural understanding, rather than relying solely on traditional credentials or outside expertise.

Memphis participants also linked public health improvement to broader forms of community power-building, including voter registration and civic participation. This suggests that respondents view health inequities not only as service delivery problems but also as products of policy, representation, and decision-making power. In this context, strengthening community voice was seen as part of strengthening community health. Participants also emphasized the need for compassionate and sensitive staff, fair employment practices, and better access to HIV prevention tools such as PrEP and PEP.

The feedback from Memphis further highlighted the importance of honest, substantive collaboration rather than symbolic inclusion. Participants called for spaces where community concerns can be raised directly and addressed meaningfully, not simply acknowledged without action. Funding and workforce support were also identified as important to sustaining community-led work. Taken together, Memphis feedback suggests that efforts to improve HIV-related outcomes must attend simultaneously to service access, workforce culture, community trust, and the broader social conditions that shape whether communities are positioned to thrive.

Miami, Florida

Miami participants drew attention to the ways invisibility, underinvestment, and structural vulnerability shape the local HIV response for several populations. A major theme was the lack of recognition of groups whose needs are often overlooked in HIV-related planning, messaging, and funding. Participants specifically pointed to limited tailored outreach for Black women, and a lack of sustained support for long-term survivors of HIV. These concerns suggest that even in high-burden jurisdictions with extensive HIV infrastructure, important populations can remain marginalized within the response itself.

Respondents also highlighted the challenges faced by smaller grassroots organizations, particularly in securing funding, sustaining operations, and receiving mentorship or technical support. Participants described the need for stronger partnership structures among nonprofits, including coalition models that would allow organizations to coordinate, advocate collectively, and share resources more effectively. This reflected a broader concern that fragmentation and competition weaken the overall response and leave smaller organizations without the support they need to remain viable.

Housing, violence, and long-term support also emerged as major issues in Miami. Participants emphasized the need for more housing options for community members who are most at risk, and for violence to be treated explicitly as a public health issue because of its impact on vulnerability, stability, and care engagement. They also identified the need for programs

specifically designed for long-term survivors, recognizing that people living with HIV over many years may face unique psychosocial and health-related challenges that are not always addressed in standard programming. Miami's feedback illustrates how local HIV work must be attentive not only to incidence and service delivery, but also to visibility, safety, stability, and the long-term well-being of communities often left at the margins of traditional systems.

The 15% Solution as a Community Engagement Methodology

A key feature of the convenings was the use of the "15% Solution" activity as a structured methodology for generating solution-focused community recommendations. As described during the meetings, participants were invited to identify a "first step" or solution that could be taken without requiring additional approval, major new funding, or action by others. In other words, the exercise asked participants to focus on the portion of change already within their control—the "15%" they could act on immediately. This framing was used to help jumpstart new initiatives and strengthen local responses through practical action.

The value of this methodology is that it shifts community engagement away from a purely diagnostic model—one that asks people only to name what is wrong—and toward an action-oriented model that centers agency, feasibility, and momentum. In communities where structural barriers are significant and often longstanding, conversations can easily become dominated by what cannot change quickly. The 15% Solution creates space for a different kind of dialogue. It acknowledges the reality of systemic barriers while also asking participants to identify where influence already exists: within relationships, outreach practices, organizational culture, local partnerships, messaging choices, and everyday decisions. This makes the method especially useful in public health and HIV work, where communities are frequently asked for feedback but less often invited to define concrete next steps.

The methodology also served an important relational function. By asking participants to propose solutions that are within their discretion to act on, the convenings elevated community members not simply as informants, but as strategists and co-creators of local change. This reinforced a core principle of the overall project: that community engagement should not be limited to extracting perspectives or validating institutional priorities, but should instead create real opportunities for communities to shape the direction of public health practice.

Why this methodology mattered

- It shifted engagement from problem identification alone toward feasible action.
- It recognized community members as strategists and co-creators, not only informants.
- It helped identify actions within existing relationships, outreach practices, organizational culture, and local partnerships.

Reporting Back to State and Local Health Departments

To deepen the utility of the Southern CBO Meet and Greet series, NACCHO convened a two-day, in-person report-out meeting with representatives from state and local health departments of key Southern jurisdictions. The purpose of the convening was to review and discuss findings that emerged from the Southern CBO Meet and Greet series and to identify implications for local and state public health practice, federal partnership, and future capacity-building efforts. Participating agencies included:

Participating health department sites

Georgia Department of Public Health	Fulton County Health Department
Cobb-Douglas Health Department	Mississippi State Department of Health
Louisiana Department of Health	Houston Health Department
Harris County Health Department	Shelby County Health Department
Miami-Dade County Health Department	Broward County Health Department

The report out meeting created an opportunity for health department representatives across the South to engage those findings collectively, reflect on their relevance within their own jurisdictions, and discuss how local, state, and federal partners might better align their efforts with community defined priorities. In this sense, the report out served not simply as a debrief, but as a structured translation point between community voice and institutional response. It allowed health department leaders to examine recurring themes across jurisdictions, identify shared barriers in the Southern policy and funding landscape, and consider practical strategies for strengthening partnerships with CBOs and other community-based entities.

Participants in the report out meeting reflected that Southern jurisdictions often operate under conditions that make public health innovation especially difficult. Participants noted examples such as states with policies that deter some populations most at risk from accessing services. As a result, local health departments and CBOs are often asked to address complex and overlapping needs while working within rigid funding rules and uneven political support.

The report out discussions reinforced that these challenges cannot be addressed by local health departments alone. Representatives acknowledged the essential role of CBOs in filling service gaps, building trust, and reaching populations that may be less likely to engage with traditional systems. They also emphasized that stronger federal-local-community alignment is needed to make HIV prevention and care more accessible, more integrated, and more responsive to local context.

Synthesis of Key Findings

These community focused efforts have made clear that strengthening the Southern HIV response will require a partnership model that is more relational, more flexible, and more accountable to community realities. Local health departments, state agencies, CBOs, and federal partners all have distinct roles to play, but their efforts must be better aligned around shared priorities.

Political and policy context matters in the South

A recurring theme in the report out was the degree to which Southern public health practice is shaped by broader political and policy realities. Participants noted that many Southern jurisdictions operate in environments marked by limited Medicaid expansion, restrictive laws, and political conditions that can make it difficult to implement affirming, and integrated public health approaches that reach and serve the variety of communities most at risk. Policies that restrict access to care for certain high risk populations were described as particularly relevant to HIV prevention and care because they can worsen mistrust, limit access, and complicate outreach to affected communities.

These realities underscore the importance of designing strategies that are grounded in local context rather than assuming a uniform national landscape. They also highlight the need for federal partners to better understand the practical constraints under which Southern jurisdictions operate. Report out participants suggested that fair presentation of evidence, strategic framing, and stronger support for local innovation may help create opportunities for progress even in politically challenging settings.

Non-medical drivers of health remain central to HIV outcomes

One of the clearest findings across both the community conversations and the report out meeting was that non-medical factors that contribute to population health continue to function as major barriers to HIV prevention, care, and overall well-being. Participants consistently pointed to housing instability, transportation challenges, food insecurity, poverty, and limited economic opportunity as conditions that directly affect whether people can access testing, remain engaged in care, adhere to treatment, or benefit from prevention tools such as PrEP.

These issues were not described as secondary or peripheral concerns. Rather, they were understood as foundational realities that shape the effectiveness of all HIV-related services. Both community stakeholders and health department representatives emphasized that siloed approaches may address symptoms of inequal access while leaving root causes intact. This finding reinforces the need for public health strategies that integrate HIV work with broader social support systems and that allow jurisdictions to address the full context in which prevention and care occur.

Funding structures often work against collaboration and local responsiveness

Funding emerged as one of the most concrete and persistent concerns across the meetings. Participants described a range of barriers that CBOs and smaller jurisdictions face when trying to access or manage funding. These included uncertainty about available funds, lack of staff capacity for grant writing, complicated financial and reporting requirements, limited technical assistance, restrictive eligibility criteria, and funding priorities that do not align with the actual work organizations are doing in their communities.

The report out discussion added that smaller jurisdictions are often disadvantaged when competing with larger, better-resourced entities for federal support. This suggests that distribution of resources in the current funding environment is not simply a question of how much money is available, but also how funding is structured, who it is designed for, and what types of organizational capacity it rewards. Participants called for more flexible and accessible funding opportunities, including mechanisms that support syndemic approaches, reduce administrative burden, and better reflect the operating realities of grassroots and smaller organizations.

Workforce development and representative leadership are critical

Both the community conversations and the report out highlighted workforce development as a key area of need. Participants emphasized that people serving communities impacted by HIV should reflect those communities in meaningful ways. This was framed not only as an issue of representation, but as a matter of trust, community responsiveness, and service quality.

Leadership pipelines, mentorship opportunities, and workforce development initiatives such as NASTADs Minority Leadership Program were discussed as important models for strengthening local capacity. The broader implication is that jurisdictions need sustained investment in developing leaders and staff who understand community realities, can build trusted relationships, and are equipped to navigate both technical and relational aspects of HIV work. Without such investment, public health systems may continue to struggle with credibility, continuity, and relevance in the communities they seek to serve.

Community engagement must be reciprocal, sustained, and actionable

Another major finding was that community engagement must go beyond one-time listening sessions or symbolic inclusion. Community participants stressed that trust is earned through sustained dialogue, visible follow-through, and shared decision-making. They expressed concern that too often institutions seek community input without creating clear pathways for that input to influence action.

Health department representatives echoed this concern during the report-out and acknowledged the importance of involving people with lived experience in planning, data interpretation, and program design. They also discussed the value of pre-meeting preparation with community leaders to ensure that participants are equipped to represent broader community interests and not placed in positions where they are expected to speak only from personal experience. Taken together, these reflections suggest that meaningful engagement requires intentional design, clarity of purpose, and institutional commitment to act on what communities say.

A syndemic and whole-person approach is necessary

The findings strongly support a shift toward syndemic and whole-person approaches to public health. Health department representatives described practical barriers to service integration, including situations in which staff are unable to make HIV or STI referrals in settings where such conversations would be clinically relevant and appropriate. These examples demonstrate how rigid program boundaries can interfere with responsive care.

Community participants similarly pushed back against narrow framing and emphasized that HIV-related work should not be disconnected from broader concerns such as violence, housing, food access, transportation, and mental well-being. The report out meeting reinforced that whole-

person care must be operationalized in concrete ways through policy, training, integrated workflows, and funding flexibility. In this context, a syndemic approach is not simply a conceptual framework; it is a practical model for designing services around the realities people face.

Local CBOs are essential partners, but they cannot do this work alone

Meeting participants consistently position CBOs as indispensable to the Southern HIV response. Community-based organizations were described as trusted messengers, service providers, advocates, and connectors to populations that may not be well served through formal public health systems. In many jurisdictions, they are the organizations most capable of responding quickly and credibly to local needs.

At the same time, the conversations made clear that CBOs cannot carry the burden of this work by themselves. Community members emphasized that local and federal government agencies must also do their part. This includes sharing responsibility for addressing non-medical drivers of health, investing in local capacity, reducing administrative burdens, and creating more equitable partnership structures. The report out discussions reinforced that strong outcomes depend on public institutions seeing CBOs not as peripheral contractors or occasional advisors, but as core partners in planning and implementation.

Recommendations for Action

For local and state health departments

- Create standing mechanisms for reciprocal engagement with CBOs and people with lived experience, including feedback loops that document actions taken in response to community input.
- Strengthen integrated workflows that address housing, transportation, food access, violence, and mental health alongside HIV prevention and care needs.
- Invest in representative staffing, leadership development, and provider training that builds trust and reflects community realities.
- Use local convenings and referral networks to reduce fragmentation and improve collaboration across organizations and sectors.

For federal partners and funders

- Design funding opportunities that are more accessible to grassroots and smaller organizations and that reduce unnecessary administrative burden.
- Support flexible, syndemic, and whole-person approaches rather than narrowly siloed program structures.
- Provide technical assistance that includes grant readiness, partnership development, data interpretation, and shared learning across Southern jurisdictions.
- Recognize the political and policy contexts in which Southern jurisdictions operate and support pragmatic local innovation.

For CBOs and community partners

- Continue building coalitions and shared learning structures that reduce competition and strengthen collective action.
- Center lived expertise as essential workforce capacity by hiring, compensating, and elevating people with direct community knowledge.
- Use the 15% Solution framework to identify near-term actions that can improve communication, referrals, visibility, and outreach right away.

For technical assistance and capacity-building providers

- Develop training on leadership, cultural humility, community engagement, grant management, and cross-sector collaboration.
- Support jurisdictions in translating meeting findings into action plans, partnership agreements, and shared accountability mechanisms.
- Package promising practices in forms that are useful to both health departments and grassroots organizations, including short tools, templates, and case examples.

Figure 6. Immediate action agenda for moving from findings to implementation.

Conclusion

This important community engagement initiative amplifies and underscores that lasting progress in ending the HIV epidemic in the South will not come from programs and policies alone, but from the strength of the partnerships that shape them. Community voice must be understood as a guiding force—one that informs priorities, sharpens strategy, and keeps public health efforts grounded in the realities of those most affected. When local and state health departments, community-based organizations, and federal partners work in genuine alignment, and when community defined needs and solutions are treated as essential to decision making, the result is a more just, responsive, and effective HIV response. Advancing this work will depend on continued investment in trust, collaboration, and whole-person approaches that recognize the lived realities of Southern communities and position those most impacted not at the margins of the response, but at its center.