

**HRSA Office of Women's Health**

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**Addressing the Unique Needs of Black Women with HIV**

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>> Well, good afternoon and thank you for joining us. I'm Nanny Smith the director of the HRSA office of women's health and on behalf of my office, I would like to welcome you to today's webinar, addressing the health needs of black women with HIV. This event is being hosted to support the observance of national women and girls HIV/AIDS awareness day which this year was March 11<sup>th</sup>. I would like to thank our partners from HRSA's HIV/AIDS Bureau for collaborating with us on this event.

We are thrilled for this opportunity to highlight the achieves and their grantees as part of OWH's women's health leadership series. Now I would like to turn things over to my colleague, Dr. Kara Beck to get us started. It Dr. Beck.

>> KARABECK: Good morning.

Thank you, Nancy, a couple of quick notes before I jump in. You will have received a notification from the Zoom system, but please do note that this webinar is being recorded. Second, closed captioning will be available for this meeting. Simply click on the closed captioning button as indicated by the letters CC. Now, I will share a bit with you about our agenda. Today we will discuss national women and girls HIV/AIDS awareness day which is the observance that we are honoring through this webinar.

I will give you a brief-over view from the perspective of the office of women's health. You will then hear from my colleague Antigone Dempsey director of HIV/AIDS Bureau division of policy and data. She will provide a high level overview of HAV and the unique needs of black women with HIV. She will introduce three dynamic speakers who will be presenting on the three topics you see on the slide.

While our packed agenda does mean that we won't have time for question and answer session, we do welcome you to share your feedback in the comments section. National women and girls HIV/AIDS awareness day is a time to build aware in about the impact of HIV on women. In 2018, 19% of new HIV diagnoses were among women, but of those, 57% were among black or African-American women even though black or African-American women only make up 13% of the population of women in the United States.

Poverty, stigma, medical distrust and fear of discrimination often prevent some black women from getting tested or from seeking care. One in nine women living with HIV aren't aware of it. Federal, state and local governments are taking actions to support routine HIV testing and encourage conversations about care for women with HIV and expanding access to prep and end PEP medications. Only 7% of women who might have been treated from preexposure prophylaxis or PrEP received a prescription in 2018. It is important that our efforts to prevent HIV and to support women with HIV continue and HRSA is well placed for this effort.

Across its Bureaus and offices including the HIV/AIDS Bureau as well as the Bureau of Primary Healthcare and Maternal and Child Health Bureau and others, HRSA supports more than 90 programs that provide healthcare to people that are geographically isolated or economically or medically challenged. We are able to do this through grants and cooperative agreements to more than 3,000 awardees.

In this way, HRSA serves tens of millions of people each year increasing access to quality healthcare. Within HRSA, the office of women's health seeks to address the health, wellness and safety needs of women across the life span, and to reduce inequities and health disparities related to sex and gender. We accomplish this through three primary functions.

We provide subject matter expertise to the HRSA administrator and other leadership on health issues impacting women. We integrate evidence-based and promising practices for women's health policy and programming across the Bureaus and offices. And we lead collaborations across HRSA and other federal and non-federal partners.

Recently we launched our women's health leadership series to highlight innovations in women's health from and for HRSA settings. With webinars on San approximately bimonthly basis, we hope to cover a variety, a broad range of topics and to highlight information relevant to a variety of stakeholders. Thank you for joining us today. And our second official installment in the women's health leadership series. We hope you will continue to connect with us and with HRSA on ensuring effective healthcare for our nation.

With no further ado, I will turn it over to Antigone Dempsey, Director of Division of Policy and Data.

>> Thank you, Kara and Nancy. Good afternoon, everyone, welcome. I see a number of our Ryan White HIV/AIDS Program recipients logged in and introducing yourselves so so glad you could join us. Welcome. Again, my name is Antigone Dempsey. We are so glad you could join us for our webinar, I know you will find this presentation informative and meaningful. I will start by providing just a brief overview of the HIV/AIDS Bureau, and then I will be turning it over to our three dynamic speakers, so next slide.

So the HIV/AIDS Bureau's vision is optimal HIV care and treatment for all, and our mission is to ensure that vulnerable people with HIV receive the care and treatment that they need in order to stay in care. So for the last 30 years, HRSA's HIV/AIDS Bureau has been administering the Ryan White HIV/AIDS Program, and you can see last August we celebrated our 30-year anniversary.

How we do that is by providing funding to cities and counties to states and local community-based organizations and clinics and like I said, I see many have joined us today because you are the folks doing this work. More than half of the people that are diagnosed with HIV in the United States are served by the Ryan White HIV/AIDS Program. In 2019 we served over 560,000 people with HIV and their families.

So that's half, over a half a million people. So in honor of national women and girls awareness day which was on March 10<sup>th</sup>, we wanted to take this opportunity to shed light on the impact of HIV on women and girls and especially black women. A little bit about the women that we serve in the Ryan White program, in 2019 we served over 48,000 women with HIV who received services through the Ryan White program. The majority of these clients are from racial and ethnic minority populations and about 61% of the women that we have served identify as black or African-American.

So this slide is looking at our viral suppression rates for black and African-American women that are served in our program. What you see here is that for women overall, about 88% of the women that we serve have been virally suppressed, which means that, number one, they are able to manage their healthcare and manage their HIV, but also that impacts also ensures that folks who have HIV are not transmitting the virus. So if you are virally suppressed, there is effectively no risk of sexually transmitting the virus to an HIV negative partner. When we look at the viral suppression rate for black and African-American women in our program that is served, you see it is slightly lower but still high especially when you consider nationally the viral suppression rate for people overall in the United States is 56%. So, again, this really shows that the work in the Ryan White HIV/AIDS Program is very successful, but we also, you know, have more work to do if we want to meet the goals of ending the HIV epidemic.

We have to address barriers that prevent black women from getting tested, accessing services and having access to culturally competent care. These include stigma, medical mistrust, poverty, but also I would say one of the biggest challenges are the systematic barriers that our country has around these issues.

I wanted to share when I was diagnosed with HIV 31 years ago, I never thought I would be here today. Back then there was no treatment, and people were dying. But I also never thought that the issues that we are facing in particular black women face today would still persist, and black women have carried the burden of HIV in terms of in the United States.

I'm very hopeful, I think that our understanding has evolved over the years around racial and economic justice issues, so I'm really hoping that our progress there will help us to be able to close that gap. So next slide, onto our presenters.

Today's presenters as you have heard already are going to be addressing a number of different pieces of work that we have been doing in the HIV/AIDS Bureau. We have Shalonda Collins Public Health Analyst in the division of policy and data, so I get to work with her, which is fantastic. She is going to highlight data and findings from a Technical Expert Panel we recently hosted. And we convened folks to talk about what are the unique needs of black women to improve HIV/AIDS prevention and services.

I want to thank co-facilitators of the expert panel, Linda Scruggs and Mr. Haze were co-facilitators for the panel and it's fantastic because of their important work.

We also have Lesherri James, at the is the peer outreach navigator at the Howard brown Health Center in Chicago. She is also a graduate of our building leaders of color project as well. She will share her perspective on her lived experience as well as insights that she has gleaned working as a peer outreach navigator.

And then finally we have Mo Wahome aids dare group, she will present on peer linkage and re-engagement of women of color initiative. This was developed as part of our special projects of national significance program. I am pleased to turn it over to Shalonda Collins. Thank you for participating.

>> Hi, everyone. Thanks Antigone. Can everyone hear me okay? Perfect. I'm Shalonda Collins, I'm a Public Health Analyst in HAB. We hosted this virtual panel over three sessions in October of last year. To start with, I will do a brief recap of data, then I will provide details regarding framework of panel discussions and end with a breakdown of the findings. Next slide. So we have already heard some rather startling numbers for the percentage of diagnoses of HIV and infection among blacks and African-American women in the U.S.

I don't want to duplicate data, but I do want to provide additional context by presenting a longer timeline of data hear which you see from 2014 through 2018. Again we see that black African-American female adults and adolescents accounted for the largest numbers of HIV infection each year compared to other racial or ethnic groups, we know that PrEP is a strategy to reduce transmission, but efforts in the past has been focused in MSN. So as Kara mentioned in opening remarks, prep coverage for women is extremely low. Black African-American women are disproportionately impacted by HIV.

These realities are what ultimately drove our decision in DPD to coordinate a technical expert panel and attempt to access narratives and experiences behind the numbers that we are seeing. Next slide. So the purpose of the Technical Expert Panel was to understand the research, clinical and patient landscapes affecting HIV prevention and treatment for black cisgender women within the Ryan White program.

Panelists discussed heavy issues like the biomedical behavioral and community level and structural dynamics that shaped their experience. We were able to create a panel of 20 participants. This included Ryan White clients, Health Department representatives from national organizations, researchers, and then probably the most prominent voice in the room, and the one that was really important to include were black women with HIV.

So a lot of lived experience. And this made for a very diverse group providing candid input. So these were our framing questions which we used to structure the conversation. We wanted the panelists to give opinions on not just clinical care issues or disparities, but also mental health needs and community engagement. The aim was to have them consider not just unique service needs across key life stages, but also different strategies and barriers to care as well as any effective models.

Because this conversation would address the critical intersection of race, behavior, and community impacting HIV related outcomes, our facilitators decided early on they needed to employ theoretical frameworks to help panelists address framing questions that appeared in previous slide. There is the framework of intersectionality. This theoretical framework considers the various identities such as race, gender, socioeconomic class or HIV status and interlocking power dynamics that make up an individual. This framework was important to include because this reality results in a lot of unique modes of discrimination for black women.

I'll touch later on those in the presentation. Next slide. The facilitators incorporated Briner's ecological model to explore the various ecosystems in which an individual operates. Each of the levels you see here, it represents inequity in trauma as well as opportunities for intervention. On the right you see the HIV safety net.

This model includes multiple domains such as access to healthcare, economic assistance, social support, and political and or civic social engagement, all of which can be addressed to some degree by Ryan White. So onto the findings. So on day 1, we posed questions relating to clinical care needs and the following points were emphasized, the first being the necessity to acknowledge this legacy of ongoing and the ongoing impact of historical trauma. Black women experience a number of societal pressures and threats across their life span. These include ongoing discrimination, constant micro aggressions and this combines to create chronic stress. This legacy of oppression is what perpetuates a lot of stereotypes about black women and it contributes to the shaming and blaming culture that has led a lot of black women to feel negatively about their life circumstances, a lot of which they are not able to control.

The second point stressed in the panel was the disconnect with clinicians which can lead a lot of equipment to have negative feelings or attitudes towards treatment. Some specific remarks that I recall from panelists were things like I wish that physicians would listen to my priorities or ask me questions about my life in general and not just treat my HIV.

Then there is the necessity for educational materials that include positive depictions of black women in real life situations messages should speak to women's emotional, mental and spiritual experiences. This includes social media as well. And lastly, recognize the diversity of this population. This population is women who acquired HIV through vertical transmission. And non-U.S. born black women who are a significant population of concern because according to 2014 data, the HIV diagnosis rate among African born black females was 5.3 times the higher of U.S. born black females. So continuing on with the clinical care issues, panelists also discuss the need to train all staff in cultural humility and to implement policies or practices that support this.

They mention things like motivational interviewing, employing staff that reflect the patient population, reducing impact of stigma and encouraging development of emotional intelligence skills. They also respect black women's personal agency and because patients are expected to have an active role in their own healthcare, they felt it necessary to train them in health literacy. Given the diversity of this population, it's important to provide a broad array of options to facilitate access to family centered co-located services and low barrier clinics which often have evening, weekend hours, drop in appointments and don't have any late penalties or no show penalties.

These services make clinics accessible to people who experience multiple challenges in their daily lives. As they commented on the need for coordination across primary HIV and specialty care, they really stress that it should focus on total wellness, and then the obvious point of creating bridges to HIV treatment and other services. One successful model that they brought up were the test and treat model where those with a new diagnosis are immediately linked to care and antiretroviral therapy. The last point, panelists discuss that black women's personal relationships in how black women need to be seen as sexual beings with male partners.

>> So for them it's important to include male partners in the conversation, they can be educated about sexual health and they have responsibility in HIV treatment, prevention and treatment. In our second session, we presented questions on mental health needs and explored the points that you see here. The first point highlights importance of understanding the importance between discrete trauma events such as rape, natural disasters and ongoing traumatic experiences such as homelessness, panelists conveyed experiencing a variety of mental health stressors in addition to those brought on by the COVID-19 and they also really thought it was important to list in trauma the fact that they are living and coping with a mindset that's prevalent among black women. There is this need to appear unaffected by setbacks and personal struggles and this mindset is instilled very early and reinforced often in most black women.

Panelists commented on having to manage often overwhelming responsibilities and burdens single handedly. This created a lot of resistance to being vulnerable and acknowledging when they needed therapy. They believe that acknowledging this need and taking steps to do so would allow black women to then tap into the resilience of their communities.

Then there is the barrier of cost. It's important to mention that here there is the perception among black women or at least in the black community that therapy is unaffordable so many black women don't consider receiving mental health services as an option.

Then there is the issue of perceptions of mental health and health services. Panelists stated that black women need to know that treatment is available. They need to know what to expect when they pursue treatment, and here terminology is incredibly important. For example, the term trauma may be triggering for a lot of women, but not for others. Some may prefer to refer to trauma as pain or actually describe physical symptoms.

Again, make services more accessible since some women may resist going to a mental health clinic due to the stigma. The group also explained that different women may prefer different modalities such as support groups versus individual therapy. They underscore the importance of alternative therapy such as art, music, dance therapy and meditation. Women need information about various treatment options so they can make informed decisions.

A lot of women may not know the difference between a psychiatrist and a therapist and they may be asked to choose between receiving medication or talk therapy but not have the option to pursue both. Clinicians need training and tools to help them address mental health needs and patients need to be educated about their mental health risk. Panelists suggested enlisting other members of the care team to conduct necessary patient education and screening.

Then in the last session, the group discussed community engagement. Panelists explain that it's really important that we recognize different members of the community are going to have different opinions, concerns, motivations and that the needs may actually differ. So you will need to use different strategies to engage with different segments of the community. Also since community members must possess knowledge to effectively participate in discussions around HIV, they felt that education should be specifically tailored to the type of discussions that are taking place.

And then there is the reality that leaders are often the target of negative feedback. They need to be supported, protected and prepared otherwise they may experience burnout or lose confidence of their communities.

So to wrap up, the themes that we encountered, that are listed here were that there is this need for a coordinated whole person health services. Multiple appointments can be a burden for women, so having multiple services available in one location allows them to see multiple clinicians in one visit. The group mentioned non-traditional approaches like leveraging services of members of the care team such as the pharmacist. This may increase access to care given that pharmacies have more accessible hours than declinics.

The last point -- clinics.

The last was to adopt trauma informed care model to help patients with a history of trauma access and remain in care. This is my last slide. I wanted to devote an entire slide to this issue and the value of lived experience because it was discussed extensively across all three sessions. Women with lived experience have knowledge of day-to-day challenges and the challenges facing their communities but panelists emphasized need for training.

They discussed the need to professionalize the roles of peers and suggested developing blueprints for organizations that could help address things like recruitment, training, career opportunities and leadership roles. Panelists felt that the work and expertise of black women with lived experience is often undervalued even when they have secured a position where they are paid, compensation doesn't constitute a living wage and as they advance within the HIV space and earn more, they may no longer qualify for Ryan White yet don't earn quite enough to preplace all of the support services available through Ryan White.

It's very stressful, I worry constantly about losing access to Ryan White services for myself and family. Many of them work as peer employees hoping their to work their way up the ladder. Employer's perceptions need to be addressed. When panelists reported being in the same position for 15 years and never receiving a promotion while another stated at decades of experience at various levels, I still get put in the consumer box. Lastly, black women with lived experience are often asked to do a lot within these organizations and this involvement comes at a great cost. Many experience burnout because they feel obligated to represent black women because if they don't, they fear black women won't have a voice at the table.

Panelists really spoke on the need for peer support to effectively advocate so that they can really serve and represent their communities well. So in closing I would like to say thank you all for listening and

for the opportunity to take part in this collaboration today. Here is my contact information in case there is follow-up. I will turn it over to Kara to introduce our next presenter. Thank you.

>> Thank you so much, Shalonda. That information was so great. I would like to now turn it over to Leshherri James, an outreach navigator at the Howard Brown Health Center.

>> Hello. Can you guys see me well?

>> You sound great.

>> Okay. So my name is Leshherri James, outreach navigator at Howard Brown Health. I also am an alumnae for Black Building Leaders of Color. What can I say? I'm so happy to be on this panel today. What I'll say about being positive for 20 years in African-American women, in celebrating Women's Month, I'll have to say that it's more a journey than going forward anything. It's hard every day. So you can't say it's like walking the walk. It's a journey. I have a 17-year-old daughter and yesterday she was interviewing me for Black Women's Month as well, and she asked me what did I fear being pregnant with her? Well, I feared being pregnant with her was that she would get the stigma from HIV, she would get the stigma from other people as well. So that's why I decided to get in this field, to be a peer to help women to understand just because you are HIV positive, that you can live a normal life.

So with my job at Howard Brown I help women that are newly diagnosed with HIV/AIDS get into care, staying in care and get undetectable. I love what I do, and I love that I'm a peer, I love that I can walk in my status every day.

As well as that, I also was a part of the Black Lead Leaders for Color, and I enjoyed that. It helped me to basically make me feel around in what I could be active in the role at Howard Brown Health. I have tons of stuff. I have been on this journey. I support all women that is positive, as well as that I think Howard Brown for giving me a chance. One day I will climb up the ladder.

>> Thank you for sharing those words with us and being able to share your experience.

Now, I will turn it over to Mo Ahome. A care manager with the AIDS care group.

>> I'm program manager at AIDS care group. I serve for peer linkage and reengage of for women of color. So an overview of the AIDS care group. We are located in southeastern Pennsylvania and we were incorporated in 1998 to serve a medically underserved region in Chester and now we have two more clinics in Sharon Hill and Reading, PA. We provide a wide range of services including HIV medical care, dental care, Hep C care, screening and treatment for STIs, prep. First the Ryan White funding. We see about 80 to 90 new patients annually and 60% of our patients. 40% of patients are women. We do see a large immigrant population which is primarily African immigrants.

So we have gone over this in the introduction, but just wanted to highlight that African or African-American or black women represent 13% of the female population in the U.S. but yet account for 58% of HIV infection diagnoses, and I think this calls for a call to action to address some of these disparities.

So in 2016 we applied for funding for a program and we got funding to implement the peer navigation program and so we hired peer navigators who are defined as HIV positive medication adherence role models living with a shared experience and a shared community membership as the populations they work with. And the women that we hired for these roles definitely fit this description. Some of their roles included case finding, conducting outreach, making phone call reminders to clients, providing Transportation assistance, making referrals, and just all around support and adherence to medication as well.

So it would get the list and have meetings so the peer navigators and the outreach staff. We would gather their contact information and peers would conduct outreach to the patient. Once we got the patient, we would schedule a medical appointment for them and then they would come into to see the healthcare provider or sometimes the healthcare provider would reach out to peer navigators about clients they thought were out of care or at risk for falling out of care. So it involved a multidisciplinary team to sort of find the patients that we needed to get back in care.

So in the three years of our intervention, we enrolled about 80 women into our program. 12 were newly diagnosed. 30% of women we had in our program were identified as being born in Africa in mostly West Africa. Some had just recently moved to the U.S. while others had been here longer than five years. The out of chair range was six months to five years not having been in care.

The average age was 45. Three American women were also co-infected with Hep C and have been cured. Three African born women also presented with active TB and they were treated for that as well. The mean CD4 baseline was 553. And then mean viral load baseline was a little over 75,000 copies.

So we collected data at six months after enrollment into the program, and at 12 months after enrollment into the program, and so viral suppression prior to enrollment was at 75 which was lower than the national average. After enrollment into care, about 97% of the women had had one primary care visit within 90 days. Retention in care was close to 82%, so they had seen at least two medical visits at least 90 days apart, and the viral suppression at 12 months since we got the women in care shot up to 86%.

So at baseline we did conduct a needs assessment just to figure out what the main barriers were and these were the most common reported barriers and this included housing, transportation, ongoing HIV stigma, substance abuse, mental health challenges.

Specifically for the African born women, there were issues with immigration, like not having the right paperwork, integration to society, culture norms, language barriers and sometimes some people wouldn't come to the clinic because they didn't have someone to translate for them.

So some of the responses of the peer program to some of these barriers is we connected clients to health and they would get picked up from their house straight to the clinic. We also provided SEPTA tokens for people who lived near public transportation hubs. We had clothing donations for not just the women, but also for their children. We had food assistance, and one of our biggest advantages is a one-stop shop model. So when clients come in, they need to see a dentist or they need to see

mental health services. They can get linked right away on campus, and so that also reduces a lost to care for other specialty services as well.

We also provided assistance for medication adherence. We had one peer that would call one of the clients every day at 9:00 a.m. to remind her to take her medication, and that was really helpful.

So I will present a few case studies from some of the women that we had in our program. So we had a 25-year-old female who was out of care for two years. She was non-compliant as indicated by her CD4 viral load. So we did conduct outreach and got her back into care. When we first met her she shared a lot about still dealing with stigma with her family. Denial of her diagnosis and just the burden of being a 25-year-old and learning how to cope with living with HIV for the rest of her life.

The peer was really helpful in sharing her personal story and how she overcame some of the similar challenges that she faced, and that was really helpful in reengaging her back into care, and her viral load did improve in the four months of the peer linkage program. It went from a little over 1 million to 80 in the four months of the intervention. This one we wanted to highlight some of the needs of the African-born women. This was a 35-year-old female from Liberia. She had just moved to the United States. She was newly diagnosed in the E.R. when she was getting treatment for a tuberculosis. She presented with a CD4 count of 68, and a viral load of over 2 million.

She didn't have insurance, and so one of the rules of the peer was to link her to case management where she was able to apply for health insurance. The peer was also helpful in delivering medication to her house, setting up transportation assistance for her visits, and also accompanying her to specialty visits in the hospital and she still linked with us, and her health has improved greatly since then.

This is one of our star peers and she plays a huge role in advocating for patients. I did ask her what she loved the most about this program, and she shared that when she got diagnosed, there was not a program like that before, and so she feels compelled to help women of color because we don't put ourselves first, and she loves what she does. I'm glad to continue to work with her.

So some of our lessons learned, Shalonda mentioned cultural humility. This is a sinuous learning process for the providers, the peers, data folks, literally everybody. We do have an immigrant population that brings a different challenge so we have to continually learn how to meet the needs of people who have different cultural background than we do.

The power story by peers is powerful and increases relatability, the clients felt safer sharing other issues beyond the medical issues of the peers because they felt like there was an extra layer of emotional support. There are multiple factors that impact linkage and retention to care, so no one size fits all. So it's important to listen to the client and get a better understanding of what might be helpful.

So early diagnosis and treatment is important for all populations. So if we are going to reduce those racial and ethnic barriers in HIV care, an understanding of each person's need is essential for effective linkage and retention and I'm glad working closely with peers provided a lot of information that they probably would have missed.

We can always learn something valuable from each and every patient. Also strong partnerships between aid service organizations, hub lick Health Departments and other providers are critical in enhancing their care continuum.

A lot of our newly diagnosed patients were referred to us from Public Health Department or the hospital system. So we find that as a great source. Enhancing the care continuum.

So post intervention, we, the peers were integrated into the general outreach team, so now they are part of the effort to find, link and retain clients through collaboration with the pharmacy team, clinical providers and the data team. We also did contribute to the peer linkage and retention manual for replication by other Ryan White clinics, and I believe that can be found in the target HIV website. The picture on the right is when we attended a training of trainers with AIDS united before the world shut down, and that was a great way for us to also just share what we have learned through the program to help train other people hoping to implement this program.

Some of the elements of the peer program like transportation assistance and other support services were sustained using program income. So we continue to do that for other patients. And we have maintained strong partnerships ask with the local department and social services.

We also received funding for a SPNS initiative targeting women, black women 2020-2023 and will utilize lessons we learned from the peer program to direct this project as well.

We will also continue training on culture, humility and motivation interviewing and we have continued partnerships with the previous SPNS partners to looking forward to continue working with HRSA, AIDS united and folks from Boston University.

And that is all I had today. Thank you.

>> Thank you so much, Mo, for your presentation, and for the important information about the intervention. I want to summarize a few themes that we heard today as I wrap up.

I think a key that we heard about is listening to the lived experience of women, and how important it is to reduce barriers to care, particularly since for women of color the barriers to care might be multilayered. I think we heard that from screening to diagnosis to viral suppression and beyond, that it's a journey as Lesherri told us, and that throughout that journey peer navigators can really be a key in providing key connections to services, to reducing stigma, and to supporting the improvement of viral suppression rates so appreciate so much all of our speakers really bringing that message home for us.

One other thing that we heard is how important it is to address barriers in ways that are meaningful to the women being served. I think that circles right back around again to listening to the lived experience. So I very much want to thank all of our speakers today who contributed to today's presentation. I want to thank all of you for being willing to come and listen to this, and I hope that if you are interested in continuing to stay connected that you will do so on the screen now you can find information to learn more about our agency and you saw contact information throughout the presentation.

So we will wrap up there. And thank you all so much and have a great afternoon.