Meeting Agenda

VIRTUAL:
Wednesday, March 27th, 2024
2:30 p.m. – 4:30 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes Prevention Committee (February 28th, 2024)
- Report of Co-Chairs
- Report of Staff
- Presentation
  - CDC NOFO by DHH
- Other Business
- Announcements
- Adjournment

Please contact the office at least 5 days in advance if you require special assistance.
The next Prevention Committee meeting is
Virtual: April 24th, 2024

Prevention Committee

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Prevention Committee
Meeting Minutes of
Wednesday, February 28th, 2024
2:30 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Keith Carter, Kenneth Cruz-Dillard, James Ealy, Gus Grannan, DJ Jack, Clint Steib (Co-Chair), Lorett Matus, Desiree Surplus (Co-Chair)

Guest: Javontae Williams (DHH), Emily McNamara (DHH), David Harvey, Brian Hernandez (DHH), Ahmea Pacheco-Branch (DHH)

Staff: Beth Celeste, Tiffany Dominique, Sofia Moletteri, Mari Ross-Russell, Kevin Trinh

Call to Order/Introductions: D. Surplus asked everyone to introduce themselves and called the meeting to order at 2:35 p.m.

Approval of Agenda:
D. Surplus referred to the February 2024 Prevention Committee agenda and asked for a motion to approve. **Motion:** L. Matus motioned; J. Ealy seconded to approve the February Prevention Committee agenda via Zoom poll. **Motion passed:** 7 in favor, 1 abstaining. The February 2024 agenda was approved.

Approval of Minutes (*January 24th, 2024*):
D. Surplus referred to the January 2024 Prevention Committee Meeting minutes. **Motion:** G. Grannan motioned; L. Matus seconded to approve the January 2024 Prevention Committee/ Comprehensive Planning Committee meeting minutes and agenda via a Zoom poll. **Motion passed:** 5 in favor 2 abstained. The January 2024 minutes were approved.

Report of Co-chairs
D. Surplus and C. Steib thanked all the members who attended the Prevention Committee's Valentine's Day event. D. Surplus reminded the committee that they were still looking for a new co-chair to take C. Steib's position. She encouraged anyone interested to contact her, T. Dominique, or C. Steib.

Report of Staff:
T. Dominique said they were incorporating the feedback on the infographics they had presented at the HIPC meeting and they hoped to finalize the changes by April.

Presentation:
-Stigma and HIV-
D. Harvey introduced himself and welcomed the committee to ask questions during his presentation. D. Harvey began his presentation with an overview of Stigma and his relation to

people living with HIV (PLWH). He said people often thought that ending HIV transmission was the ultimate goal. However, the true ultimate goal was to find a cure for HIV. He sought to illustrate how people felt shame was shaped by the period they had lived in. He said the content of his presentation was based on his experience as a social worker, his collaboration with Prevention Point, and as a person living with HIV.

He described the first experiences of shame as starting from infancy. He quoted Franz Bash that the infant's behavioral adaptation was dependent on effective communication with the caregiver. The failure of a positive facial expression signaled a reaction to the loss of the other, indicating social isolation and the need for relief from that condition. He said the experience of shame in later life harkens back to this time of life when shame was not only uncomfortable but was also an existential threat. D. Harvey defined the difference between guilt and shame. Guilt occurred as the result of an action while shame was connected to identity. He argued that PLWH grappled with the shame that was bound to their core identity and not the behavior that led to having HIV. He said PLWH were often minorities and HIV exacerbated the issues that minorities faced. HIV-related shame was not only tied to perceived differences and maladies but also tied to a fear of transmission. He emphasized that this was why the message of undetectable equal untransmittable (U=U) was important. He stated that HIV stigma was especially persistent since the societal response often turned to victim blaming for HIV transmission. He discussed how people were historically afraid to use the term AIDS and said the fear of saying AIDS was in itself a form of stigma.

D. Harvey provided an overview of the population, men who have sex with men (MSM), based on the time period they had lived in. Those born before 1971 and experienced the era of 1981 to 1996 generally saw HIV/AIDS through the lens of trauma. Those born between 1972 and 1988 were heavily exposed to the sensationalization of HIV on the news and societal adoption of stigma towards homosexuality and HIV/AIDS. Those born after 1988 experienced less trauma and stigma than earlier generations, since HIV had become more well-known and manageable due to advancements in medicine. Overall, D. Harvey said they were still experiencing trauma that had carried over from the first epidemic even though the conditions that promoted the transmission of HIV had changed over time.

He said stigma was defined by the environment and historical context. D. Harvey used Ryan White who would experience stigma differently than other PLWHs due to the circumstance of Ryan White's HIV transmission. D. Harvey said those who knew stigma felt, internalized, and were anxious about enacted stigma. D. Harvey then listed and defined the various types of stigma such as labeling, stereotypes, devaluing, discriminating, ignorance, and prejudice.

After reviewing the various forms of stigma, D. Harvey described how stigma affects a person. He said stigma often led to decreased access to employment, housing, treatment, and interpersonal relationships. He said stigma promoted a negative self-image leading to poor mental health disorders, including addiction. He said stigma leads to stress in minorities. People with stigma, he said, often avoided protective factors. He then listed the contributing factors leading to HIV stigma. These factors were a lack of awareness of people with HIV/AIDS, burnout, burnout such as compassion fatigue, poor role models and leadership, and insufficient education about PLWH.

D. Harvey turned to the audience and asked them about their experience with HIV stigma in the workplace. He reminded the committee that even if HIV was not spoken about, it did not mean HIV and PLWH disappeared. K. Carter said employment listings and work environment had treated him and other PLWHs as unclean. The thought reminded D. Harvey that people on Grindr were of a similar mindset where they treated PLWH as unclean. D. Harvey said this language was often used to describe people who used drugs. G. Grannan said the language was prevalent among those who are in the supportive profession. He said he often had to convince others to define a drug test as either positive or negative rather than dirty or clean.

G. Grannan reminded the committee it was the anniversary of HIV status decriminalization. He asked D. Harvey to speak about HIV status and its relation to the law in Pennsylvania. D. Harvey said he moved to Iowa for a graduate school program shortly after he tested positive. He was informed while living there that if PLWH had sexual relations without disclosing their status, they could be incarcerated for up to 20 years. He remembered there was a PLWH in Iowa who had sexual intercourse without disclosing their status, but had used a condom. D. Harvey said that person was sent to jail for 20 years and classified as a sex offender. He said he was very active in activism. After 6 years, the law was changed so that HIV transmission had to occur before the PLWH was convicted. He said he did not believe Pennsylvania has a similar law. G. Grannan said Pennsylvania did have such a law and was a model for other states in the 1980s as it was the first state to enact those laws. He said the main populations convicted under the law had mainly been sex workers and people who used drugs. D. Harvey said these laws were harmful since they encouraged people to remain untested and untreated. K. Carter said the onus of protecting their health should not solely fall on PLWH. He said people with other health conditions such as syphilis were not jailed if they did not disclose their status. D. Harvey presented the committee with a chart of terms that they should use when addressing HIV stigma. He underscored that HIV was no longer a death sentence.

D. Harvey went over the reasons for stigmatizing behavior. He said the way to remove stigma was to emphasize and acknowledge the humanity of the other person. He went over some of the tactics that one could use to confront stigma. These steps were to use humor, self-talk, self-assertion, and understanding recognition of risk. He said institutions were unsafe and to confront stigma and they should advise caution and reasoning before doing so. His final message in the presentation was not to dissociate themselves from shame. He said that topics such as sex should not be discussed as a shameful topic and they should recognize the topic as part of the human experience.

Discussion Item:

-CDC NOFO Update by DHH-

J. Williams and E. McNamara would be presenting the Notice of Funding Opportunity (NOFO) update. The CDC had been funding HIV prevention and surveillance. He said the cycle had started in 2012-2017 cycle. He said they were in the 2018-2023 cycle. From this period, the End of the Epidemic (EHE) cycle was created. He said the EHE would be ending in 2024 because the CDC wanted to roll the funding and program into the core activities that the CDC funded for the entire country. The cycle would be called PS20047 and would last from 2024 to 2029.

PS24-00047 was a NOFO where the CDC announced funds for a cooperative agreement to implement high-impact HIV prevention and surveillance programs. The program affected 8 cities including Philadelphia and emphasized a comprehensive approach to prevention and surveillance. This was known as a whole-person approach. The NOFO sought to increase knowledge of HIV status, reduce HIV transmission, prevent new HIV infections, improve linkage to care and viral suppression, and maintain the elimination of perinatal transmission. There were 60 awards expected to be worth a total of $2.9 billion over 5 years.

The CDC had wanted recipients to utilize epidemiological data for a data-driven approach to distribute funding resources throughout the jurisdiction according to where the greatest need was. J. Williams said the CDC had asked the recipients to improve their data collection so it is accurate and could be shared among other health organizations. J. Williams stated that the CDC expected recipients to collaborate with other health departments and organizations that were not funded by the CDC. He said there was an expectation that they should be addressing the social and economic factors along with testing to prevent HIV transmission.

J. Williams reviewed the populations that were most impacted by the epidemic. These populations were MSM, transgender persons who have sex with men, people who inject drugs, Black and Hispanic persons, youth 13 to 24 years of age, and young adults aged 25 and 34 years of age. K. Carter reminded the committee that older adults were an important vulnerable population they must also look to support. J. Williams emphasized that they must address health disparities because these populations were the most vulnerable.

J. Williams turned the role of presenter to E. McNamara. She thanked J. Williams and continued the presentation. Her portion of the presentation involved reviewing the key goals and strategies required under the new NOFO. The first strategy was to increase knowledge of status by 95% by ensuring all people with HIV receive a diagnosis as early as possible. The activities for this goal looked to improve testing in both healthcare and community settings. The second core strategy was to implement a comprehensive approach to treat people with diagnosed HIV infection rapidly and effectively to achieve viral suppression. The key activities were to link to HIV medical within 30 days all people who tested positive for HIV and to support people with diagnosed HIV infection to receive rapid and effective care.

The third strategy was to prevent new HIV transmission by increasing PrEP coverage to 50% of estimated people with indications for PrEP, increasing PEP services, and supporting HIV prevention, including prevention of perinatal transmission, harm reduction, and syringe program (SSP) efforts. The key activities to support this goal were to promote awareness and access to PrEP and PEP services and conduct condom distribution. They were to conduct social marketing campaigns and other communication efforts to increase awareness of HIV and promote testing, prevention, and treatment. E. McNamara said they would also be required to conduct perinatal, maternal, and infant health prevention and surveillance activities.

The fourth strategy was to respond quickly to HIV clusters and outbreaks to address gaps and inequalities in services for communities who need them. She said the key activities were to develop an HIV cluster detection and response (CDR) leader and coordination group to oversee

CDR activities such as communicating and collaborating with the community and creating a CDR plan to determine cluster response.

Core strategy #5 was to conduct HIV surveillance activities as described in the Technical Guidance (TG) for HIV surveillance programs to ensure accurate, timely, complete, and actionable data. Activities to achieve this goal were to conduct data collection, maintain data systems, and conduct data management activities. They were also to conduct analysis, dissemination, and evaluation.

The final core strategy was to support community engagement and HIV planning. The key activities were to conduct strategic community engagement and maintain an HIV Planning Group (HPG).

E. McNamara returned the presenter role to J. Williams. J. Williams said they would be skipping the sections on CDC evaluation and performance measurement strategy. He summarized the funding restriction portion of the presentation. He said recipients could not use the funding for research, or purchase furniture or equipment. He said they could not purchase syringes but they could pay for the salary of staff working at SSP.

J. Williams said the presentation was complete and he opened the meeting to a discussion with the committee. G. Grannan said the city government had reversed their position on SSP and restricted bus transportation in Kensington. He said it was difficult to believe the health department was to achieve its harm reduction goals when the city government planned to remove harm reduction from the city. J. Williams acknowledged G. Grannan's concerns and said they must argue for SSP and harm reduction through scientific evidence. He said because their federal partners were advocating for harm reduction, harm reduction would be their approach. He said they would be limited by the city government and would need to wait until it was politically expedient.

K. Carter asked how DHH was to encourage community members to participate in the process such as HPG. J. Williams said they would think of ways to increase participation. M. Ross-Russell said they were not allowed to provide cash to encourage participation. The extent of what they could was to provide gift cards. J. Williams said they were discussing an EHE group and focus groups within DHH but they did not have concrete plans yet. K. Carter asked about housing opportunities within the NOFO. J. Williams said this was outside the scope of the NOFO.

L. Matus asked if the HIPC could send a letter requesting more information about the city's plan once they have removed harm reduction in the city. J. Williams said they could send the contacts for the people who were overseeing this process. L. Matus said she felt that the city was leaving her out of the process when they decided to make these kinds of decisions without the HIPC's input. J. Williams encouraged L. Matus and the other HIPC members to continue advocating for harm reduction.

T. Dominique asked for more details about the $750,000 reduction in the budget and asked if the NOFO would cover the reduction. J. Williams said the NOFO was their normal 5-year funding.

He said the CDC created a cooperative agreement award by combining the EHE funding and normal prevention funding. He said the CDC took some funding away from the EHE funding and the normal prevention funding. He said they would need to account for inflation and salary raises for staff for people in the government. M. Ross-Russell asked if rapid testing was something they were not supposed to do since the city was not paying for the tests. J. Williams replied that the city was paying for tests but they, and the CDC were not emphasizing the usage of the tests. K. Carter asked if they could use carryover funding from the current funding cycle and bring it over to the next cycle. J. Williams said they could not. He said if they did not spend the funding by the due date, they would be required to return the funding to the federal government. C. Steib asked when would the funding trickle down to the agencies. J. Williams said the funding cycle would start on August 1st once the applications were submitted. C. Steib asked if the budget reduction meant that new services would not be funded. J. Williams said that was not necessarily the case and he trusted that Dr. Brady would oversee they were using the budget efficiently.

Any Other Business:
None.

Announcements:
G. Grannan reminded the committee that the date was the anniversary of the decriminalization of HIV. He said that it was still a felony in Pennsylvania to not disclose their HIV status before intercourse.

Adjournment:
D. Surplus called for a motion to adjourn. **Motion:** L. Matus motioned, K. Carter seconded to adjourn the February Prevention Committee meeting. **Motion passed:** Meeting adjourned at 4:27 p.m.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:

- February 2024 Prevention Committee Meeting Agenda
- January 2024 Prevention Committee Meeting Minutes