NYS AIDS Advisory Council End the Epidemic Subcommittee: Black MSM Advisory Group

Strategies for Implementing the Blueprint with Black MSM in New York State

At just over 3.5 million, New York State has by far the largest Black population of any state in the nation. New York City now has the largest Black population of any city in the United States with 3.4 million Blacks living in its city limits. In the rest of the state commonly referred to as Upstate New York, Blacks live almost entirely in urban areas and mostly within city limits. These areas are mid-sized cities with mostly manufacturing and new-technologies based economies such as Rochester, Buffalo and Syracuse. Smaller Black communities can be found in cities and towns such as Poughkeepsie, Newburgh, and Monticello.

HIV prevalence, incidence, and risk are known to be consistently high among young MSM, Black MSM, and transgender women. Accelerated implementation of combination prevention in the context of expanding primary care is essential for advancing a robust prevention agenda that effectively complements strategies already underway to improve HIV care continuum outcomes. The distribution of HIV prevention resources does not mirror or adequately track the current epidemic, however. Moreover, while it well known that Black MSM are overrepresented in new HIV cases, the nuance and complexity of Black life for MSM in New York has not be adequately characterized as part of the dominant HIV prevention and care narrative.

The implementation strategies developed by the Black MSM Advisory Group embody five themes that relate to the importance of social conditions in shaping health outcomes for Black MSM, including strategies for reducing the number of new HIV infections and HIV/AIDS related mortality. These themes permeate the implementation strategies identified across the five selected blueprint recommendations in this report.

1) Solutions for ending the epidemic among Black MSM in New York State must incorporate a population perspective that focuses on addressing social determinants of health.
2) The complexity of interactions that influence the epidemic in Black MSM require solutions that are multi-level and that engage stakeholders across community and government sectors.
3) Attention must be given to the social context that shapes behaviors, including sexual behavior, healthcare seeking behavior, and treatment/care (dis)engagement.
4) HIV prevention and care must incorporate life course and developmental perspectives that build appropriate socioemotional assets for Black MSM before the onset of sexual activity and that fosters healthcare engagement and patient-provider collaborations before an HIV diagnosis.
5) Environmental and other non-behavioral factors (e.g., stigma, stress, trauma) may impact Black MSM's behavioral and biological (including mucosal and systemic immunology) vulnerability to HIV and thus must be engaged as interrelated phenomena in efforts for HIV prevention and care.

An integrated syndemic-intersectional orientation is required to address the spread of HIV in Black communities. Syndemic theory posits that social disparities heightens the risk of epidemics among "*socially devalued groups*," and that epidemics in these contexts are often mutually reinforcing. Syndemics involve the spread and persistence of mutually reinforcing health problems typically found in communities with unfavorable living conditions (*e.g., economic hardship, material deprivation, social disruption, inadequate health care*). There are other social forces that impact the magnitude of the effects of syndemics on Black MSM such as homophobia and anti-Black racism including institutionalized racist practices that exclude or limit access to opportunities in a range of life domains (e.g., healthcare, employment, housing). The implications of an integrated syndemic-intersectional require that solutions for ending the epidemic in Black MSM require approaches that are both multi-level (e.g., structural, behavioral and biomedical) and multi-sectoral (e.g., public health, employment, human services, education, public safety). The strategies produced by this advisory group is one important step forward towards ending the epidemic that will be followed by sustained collective community advocacy to support their implementation across the state.

NYS AIDS Advisory Council End the Epidemic Subcommittee: Black MSM Advisory Group

The Denver Principles

(Statement from the advisory committee of the People with AIDS)

There is no better way to cite the history of the PWA self-empowerment movement than to quote the principles articulated in Denver in 1983. They are as relevant and powerful today as they were then. As a group of Black non-Latino and Black Latino MSM who are either living with or otherwise affected by HIV/AIDS, we embrace the Denver Principles and assert that they reflect values that must guide the implementation of the strategies identified by this work group.

We condemn attempts to label us as "victims," a term which implies defeat, and we are only occasionally "patients," a term which implies passivity, helplessness, and dependence upon the care of others. We are "People with AIDS."

RECOMMENDATIONS FOR ALL PEOPLE

1. Support us in our struggle against those who would fire us from our jobs, evict us from our homes, refuse to touch us or separate us from our loved ones, our community or our peers, since available evidence does not support the view that AIDS can be spread by casual, social contact.
2. Do not scapegoat people with AIDS, blame us for the epidemic or generalize about our lifestyles.

RECOMMENDATIONS FOR PEOPLE WITH AIDS

1. Form caucuses to choose their own representatives, to deal with the media, to choose their own agenda and to plan their own strategies.
2. Be involved at every level of decision-making and specifically serve on the boards of directors of provider organizations.
3. Be included in all AIDS forums with equal credibility as other participants, to share their own experiences and knowledge.
4. Substitute low-risk sexual behaviors for those which could endanger themselves or their partners; we feel people with AIDS have an ethical responsibility to inform their potential sexual partners of their health status.

RIGHTS OF PEOPLE WITH AIDS

1. To have as full and satisfying sexual and emotional lives as anyone else.
2. To quality medical treatment and quality social service provision without discrimination of any form including sexual orientation, gender, diagnosis, economic status or race.
3. To full explanations of all medical procedures and risks, to choose or refuse their treatment modalities, to refuse to participate in research without jeopardizing their treatment and to make informed decisions about their lives.
4. To privacy, to confidentiality of medical records, to human respect and to choose who their significant others are.
5. To die—and to LIVE—in dignity.

Greater and Meaningful Involvement of People with HIV and AIDS (GIPA/MIPA)

In the submission of this report to the New York State Department of Health AIDS Advisory Council, Ending the Epidemic subcommittee, we endorse the application of GIPA and MIPA principles to the implementation process. There should be greater involvement of Black MSM in the development, execution, monitoring and evaluation of policies and processes developed to support the implementation of these strategies across New York State, including in the City of New York.

NYS AIDS Advisory Council End the Epidemic Subcommittee: Black MSM Advisory Group

Focus on Protecting Human Rights of Black MSM

Using human rights concepts, one can examine the extent to which governments are progressively respecting, protecting, and fulfilling their obligations for all rights-civil, political, economic, social, and cultural-and how these government actions influence patterns of infection and concomitant responses. HIV/AIDS policies and programs can be improved by a systematic review of how and to what extent interventions are both respectful of human rights and of benefit to public health. HIV prevalence is highest among Black gay and non-gay identified MSM and Black transgender women in the LGBTQ population. The drivers of HIV infection among LGBTQ are low self-esteem, depression, and risk from injection drug use. Black MSM remain the population most heavily affected by HIV infection. Risks within society include social stigma, family rejection, peer harassment, and interaction with high-risk partners.

Interventions prescribed in the newly penned Integrated HIV Prevention and Care Plan 2017- 2021 should clearly indicate prioritized evidence-based public health (EBPH) interventions and services with proven efficacy among Black MSM. Additionally, funding should follow the epidemiology and directly funded minority run and minority serving organizations.

BLACK MSM ADVISORY GROUP MEMBERSHIP

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NYS AIDS Advisory Council End the Epidemic Subcommittee: Black MSM Advisory Group

Blueprint Focus Area	Identify persons with HIV who remain undiagnosed and link them into care

#1 RANKED PRIORITY

BP4 IMPROVING REFERRAL AND ENGAGEMENT

1. Create personalized, client-driven HIV linkage plans for individuals who are newly diagnosed and lost to care.
   a. Create modules for assessing patients' willingness to link to care (snapshot of the client's life as a measure to determine successful linkage)
   b. Create a linkage goals roadmap (a visual of the linkage process for the client)
   c. Connect and follow (connect the client to medical services and follow up with client every three months for the first two years)
   d. Consider a graduated monthly to yearly engagement frequency step down (For clients who reach virally suppressed goals, follow up may not be needed as frequently. Refocus on engaging clients that may have issues reaching their goals).

2. Leverage advances in biomedical HIV prevention and treatment to improve adherence for HIV non-infected Black MSM (HIV pre-exposure prophylaxis [PrEP] and post-exposure prophylaxis [PEP]) and Black MSM living with HIV (antiretroviral treatment and viral suppression)

#2 RANKED PRIORITY

BP2 EXPAND TARGETED TESTING

1. Improve awareness of personalized testing options that can be tailored to individual needs, such as home-based HIV testing, clinic/community-based organization testing, couples-based HIV testing or friends-based HIV testing.

2. Establish designated community clinics for late night expanded testing

3. Integrate routine HIV/STI and Hep C testing into general health screenings visits.

NYS AIDS Advisory Council End the Epidemic Subcommittee: Black MSM Advisory Group

Blueprint Focus Area	**Link and retain persons diagnosed with HIV in care to maximize virus suppression so they remain healthy and prevent possible transmission**

#1 RANKED PRIORITY

BP8 ENHANCED AND STREAMLINE SERVICES TO SUPPORT THE NON-MEDICAL NEEDS OF ALL PERSONS WITH HIV

1. Continuous monitoring of HIV viral load
2. Identify and train Black MSM medical providers to monitor Black MSM patient viral loads.
3. Identify and train Black MSM peer educators to serve as patient navigators and treatment adherence counselor who can facilitate linkage and retention of Black MSM in HIV primary care.
4. Provide educational scholarships with the goal of increasing the number of Black MSM who enroll in and graduate from health professional schools and ultimately obtain licensure for professional practice in the State of New York.
5. Create benchmarks and indicators for the integration of behavioral health services (substance abuse/mental health) into primary care to ensure linkage, retention and care.

   **NOTES

   a) Create incentives for primary care providers to take integrated approaches to care delivery with Black MSM.
   b) Collaborate across New York States agencies to support integrated care delivery. For example, Office of Mental Health and Office of Alcoholism and Substance Abuse
6. Ongoing assessment of cultural responsiveness of healthcare and service environments that are funded by the AIDS Institute or other New York State Agency.

   **NOTES

   a) Black MSM Advisory group members are willing to work with the AIDS Institute to address and implement this particular strategy recommendation
   b) This recommendation should be applied to all agencies in New York State that receive direct or indirect funding by the AIDS Institute

NYS AIDS Advisory Council End the Epidemic Subcommittee: Black MSM Advisory Group

#2 RANKED PRIORITY

BP9: PROVIDE ENHANCED SERVICES FOR PATIENTS WITHIN CORRECTIONAL AND OTHER INSTITUTIONS AND SPECIFIC PROGRAMMING FOR PATIENTS RETURNING HOME FROM CORRECTIONS OR OTHER INSTITUTIONAL SETTINGS

1. Establish a transitional health and coordination program at the local level under direct jurisdiction of the county or city health department responsible to coordinate the provision of pre-release linkage to care and single point of entry for health care service referrals for chronically ill persons.
2. Customize/tailor materials in ways that is sensitive to the dynamics of sexuality within the correctional facilities.
3. Target training and capacity-building assistance to healthcare providers who work in jails/prisons (and to providers who work with these institutions) on responsive approaches to working with Black MSM pre-release or in transitioning to community re-entry.
4. Identity gay and non-gay identified MSM leaders and adopt the Popular Opinion Leader model or other home grown intervention model(s) for the dissemination of health referral information in correctional settings.
5. Develop and/or implement programs that collaborate across multiple sectors/ departments leading to more effective discharge planning and a clear linkage plan to HASA/other entry points to care.
6. Expand application of the above strategies to other types of institutions that use legal detention.

NYS AIDS Advisory Council End the Epidemic Subcommittee: Black MSM Advisory Group

Blueprint Focus Area	**Provide access to PrEP for high-risk persons to keep them HIV negative**

#1 RANKED PRIORITY

BP11: UNDERTAKE A STATEWIDE EDUCATION CAMPAIGN ON PREP AND NPEP

1. Implement a Message Creation Process (Phase 1) that will involve and promote Black LGBT organizations (with a focus on Black MSM), groups and individuals. Message creation should include formative research methods such as focus groups, surveys and online content analysis of Black MSM in the State of New York.
2. Implement a Message Creation Process (Phase 2) utilizing efforts coordinated by and in close collaboration with Black MSM from across the State of New York
   a. Using data from Phase 1, design and create culturally responsive messages on PrEP and nPEP for use, promotion and dissemination both community wide and for specific sub-populations within the Black MSM community.
3. Implement and disseminate PrEP/nPEP/Preventative care messaging campaign (Phase 3). Develop media and outreach strategies to include the use of print, web based and mobile platforms and development of mobile apps which incorporate PrEP/nPEP/preventative care messages created by and for Black MSM across the State of New York, including the City of New York.
   ***NOTE: Implementation and dissemination should include a detailed evaluation plan.
4. Evaluate the implementation of community-based campaigns to inform the development and diffusion of other culturally responsive campaigns to raise community awareness of PrEP and nPEP for Black MSM.

#2 RANKED PRIORITIES

BP12: INCLUDE A VARIETY OF STATEWIDE PROGRAMS FOR DISTRIBUTION AND INCREASED ACCESS TO PREP/NPEP &

BP14: DEVELOP MECHANISM TO DETERMINE PREP/NPEP USAGE STATEWIDE

1. Implement a statewide PrEP/nPEP and preventative care educational effort for all medical providers. This would entail optional ongoing trainings for Continuing Education Units (CEUs), information sessions for medical providers statewide, along with additional educational opportunities tailored to the needs of BMSM in relation to PrEP/nPEP/preventative care.
   ***NOTE: This strategy should also include the development and use of a detailed evaluation plan

2. Produce data reports based on AIRS, eSHARE, and additional data collected from various platforms used to monitor client medical records. The reports should be shared at statewide engagement tables that would support ETE goals and objectives as well as engage communities of Black MSM who demonstrate low PrEP/nPEP use and adherence.
    a. *Assist in the promotion and dissemination of the newly created PrEP/nPEP messages* targeting the most at-risk Black MSM communities. Non-traditional organizations and agencies which work closely with communities of Black MSM should be engaged as well (e.g., cultural, religious, neighborhood, lifestyle organizations/agencies).
    b. Tables should engage and collect data within geographical areas and social networks of Black MSM that have high incidence of HIV transmission, as well as communities of Black MSM which demonstrate low PrEP/nPEP use and adherence.
    c. Quarterly collection and analysis of data from eShare, AIRS, and other platforms used to collect medical/health data on Black MSM clients. This same data should also be collected from institutions regardless of funding source and data collection platform.
3. PrEP/nPEP monitoring data among Black MSM should be collected and analyzed. Data should be uploaded onto the NYS ETE dashboard.

#3 RANKED PRIORITY

BP13: CREATE A COORDINATED STATEWIDE MECHANISM FOR PERSONS TO ACCESS PREP/NPEP AND PREVENTION FOCUSED CARE

1. Utilizing data targeted at clients and providers, collected from focus groups, client/provider satisfaction surveys, and well as statewide engagement tables (see 1. Under BP12), identify common barriers to accessing prevention focused care, more specifically PrEP/nPEP.
2. Identify and implement strategies to eliminate and/or reduce common barriers to accessing PrEP/nPEP.
3. Develop a coordinated statewide pathway serving as a mechanism which links Black MSM to PrEP/nPEP and preventative care.
    ***Note: this mechanism should prioritize ease of access for the most structurally vulnerable Black MSM

NYS AIDS Advisory Council End the Epidemic Subcommittee: Black MSM Advisory Group

Blueprint Focus Area	Recommendations in support of decreasing new infections and disease progression.

#1 RANKED PRIORITY

BP18: HEALTH, HOUSING, AND HUMAN RIGHTS: FOCUS ON BLACK MSM

Promoting the health, safety, and dignity of LGBT communities is a vital part of ending the HIV epidemic in New York State. Culturally competent service models that address individual, group and community-level barriers to LGBT identified individuals engaging and linking to care must be addressed. Utilization of peer led programming may better engage people in activities that support employment, life skills training, and mentorship. Considering the major impact HIV has had on populations such as gay and non-gay MSM and transgender persons, special attention needs to be given to developing infrastructure to allow these communities to play a direct role in identifying and addressing their own needs. [CR30, CR33].

1. Expand the operational definition of Linkage to Care to include more than one primary care visit.
    a. Develop measures that highlight secondary and tertiary referrals.
    b. Emphasize mental health parity under the Affordable Care Act
    c. Emphasize the impact of a syndemic orientation on HIV incidence and prevalence in Black/African American communities in New York State.
    d. Identify counseling, testing and referral (CTR) sites as point of use/point of entry as well. These should be significantly increased in Black MSM communities.

2. Leverage peer-based efforts to improve service delivery and coordination with Black MSM
    a. Considerations should be made for how peer-based techniques can be leveraged as assets for all implementation strategies for MSM (e.g., peer-based HIV testing, peer support for PrEP adherence)
    b. Use peer-based and social network techniques to estimate the population size of Black MSM in the State of New York
    c. Design peer-based methods to assess the needs, barriers and gaps of Black MSM sub-groups of Black MSM.
    ***Note: there may be similarities but there are also differences that must be recognized
    d. Incorporate peer-based techniques into strategies, models, services designed to address both unmet needs and those who are unaware of their HIV status and for HIV diagnosed Black MSM who are not currently in care
    e. Establish a peer workforce of Black MSM for (1) engagement, (2) linkage and retention in care and (3) patient education and navigation

3. Housing Policy
    a. Articulate the need for affordable housing and identify existing barriers for Black MSM.
    b. Increase the availability of and access to emergency housing – particularly for Black MSM <30 years of age

c. Address the Section 8 restriction pertaining to criminal justice involvement.
d. State Income, Education and Communication regarding income discrimination and "Know Your Rights"
e. Connect housing needs with adequate medical, mental and behavioral health services coordination

4. As the End the Epidemic blueprint seeks to ensure that the housing need is meet for vulnerable low-income and homeless New Yorkers living with HIV/AIDS, NYS must equally work to ensure that housing discrimination, particularly Source of Income Discrimination (SoID), does not prevent access to long-term/permanent stable and affordable housing.

5. Human Rights –
    a. Each segment of the NYS EtE Blueprint should embody the essence of the 1983 Denver Principles.
    b. Comprehensive Sexuality Curriculum should include the World Association of Sexology Declaration of Sexual Rights

Summary

Supporting Evidence for Peer-based efforts:

- Despite the benefits and efficiencies associated with evidence-based programs or policies, many public health interventions are implemented on the basis of political or media pressures, anecdotal evidence, or "the way it's always been done". Barriers such as lack of funding, skilled personnel, incentives, and time, along with limited buy-in from leadership and elected officials impede the practice of evidence-based public health (EBPH). The wide-scale implementation of EBPH requires not only a workforce that understands and can implement EBPH efficiently but also sustained support from health department leaders, practitioners, and policy makers.

- What are the most important benefits or "value added" of adopting consumer-based strategies? What do consumers offer that makes them valuable in such roles?
    - Social Networks – Every PLWH in care knows 2-3 PLWH not in care
    - Flexibility – Play many roles and can change to meet new needs.
    - Assist in the transition to "chronic disease model" – Empower to manage HIV disease.
    - Lower costs than other models
    - Proven effectiveness of community health workers in other healthcare situations
    - Enhanced consumer involvement in community planning process

Housing:

- Housing must be considered a first-line response to the personal health problems of homeless individuals. Moreover, the creation of additional affordable housing must be understood as a critical public health responsibility, for the control of communicable disease and for efficient and effective health care planning and spending.
- Medicaid expansion under the Affordable Care Act (ACA) creates a new imperative at federal, state, and local levels to cost-effectively meet the needs of newly covered homeless individuals, recognizing the inarguable link between health care and housing.

- NYS ranks in the bottom 10 percent of owner occupied units.[1] The 2005 National Housing and HIV/AIDS Research Summit concluded, "recent studies show strong correlations between improved housing status and reduced HIV risk, improved access to medical care and better health outcomes."[2]
- Poor health puts one at risk for homelessness. Half of all personal bankruptcies in the US are caused by health problems,[3] too often and too quickly leading to eviction and homelessness.
- Dispossessed people often land with friends or family at first, but their living arrangements are tenuous, and break down particularly quickly for those with mental health or substance abuse conditions.
- Homelessness puts one at risk for poor health. Exposure to infection, to the elements, and to the violence of the streets is common. Lack of control over nutrition or personal hygiene or sleep demeans and debilitates homeless people. Risky survival behaviors are the currency of the streets. The psychological toll is as dire as the physical. Furthermore, homelessness complicates efforts to treat illnesses and injuries. Neither health care financing nor the structure of the health care delivery system is attuned to the particular needs of homeless people.[4]

#2 RANKED PRIORITY

BP20: EXPANDED MEDICAID COVERAGE FOR SEXUAL AND DRUG-RELATED HEALTH SERVICES TO TARGETED POPULATIONS:

To end the epidemic, targeted prevention and care efforts must be made for NYS residents that are at high risk for HIV who are non-insured, underinsured or privately insured and want to keep their sexual health services confidential. The provision of a benefit that is similar to the current NYS Family Planning Benefits Program (FPBP) would cover sexual health services, such as PrEP and non-occupational post-exposure prophylaxis (nPEP), STI screening and treatment, HIV management, Hepatitis C testing and treatment, family planning services, and transgender transition services [CR31, CR41, CR43].

1. Throughout the Blueprint, underscore the connections between substance use and addictions on HIV transmission (for Black MSM at high risk for HIV infection) and their impact on retention in care/treatment for Black MSM LWHA.
   a. Increase mental health parity
   b. Increase funding for Benefits Navigators and patient navigators with emphasis on greater peer involvement.
   c. Fund EBPH interventions that address a concomitant phenomenon that contribute to HIV transmission and acquisition.

2. Throughout the EtE, emphasize bundling of CTR for HIV and HCV
   a. Increase the number of CLIA and CLEP waivers for minority run and minority serving CBOs

3. Explore impact of Patient Protection and Affordable Care Act (ACA) on Children's Health Insurance Program (CHIP) and increasing pediatric coverage to age 26 for Black MSM.

[1] US Census 2011 ACS: Includes Black and Black in combination with other race(s).
[2] National AIDS Housing Coalition. Housing is the foundation of HIV prevention and treatment: results of the national housing and HIV/AIDS research summit. Washington DC, 2005.
[3] Himmelstein, D, et al. Illness and injury as contributors to bankruptcy, Health Affairs. February 2, 2005.
[4] Institute of Medicine. Homelessness, Health and Human Needs. National Academy Press: Washington, DC, 1988.

a. Encourage insurers to advertise mental health and behavioral health parity.
b. Advocate for lower co-pays for both inpatient and outpatient services/programs.
c. Increase the duration of paid treatment.

4. Throughout the BP, emphasize increased coordination between OASAS and AIDS Institute. OASAS' Division of Practice Innovation and Care Management has trainings on Medicaid Managed Care that can assist with guidance.

5. Utilize the double helix HIV Prevention and Care Continuum
a. Consider STI screenings Point-of-Use/Entry for medical and related social services.
b. Emphasize importance of ARV access and utilization to community viral load containment strategies.

6. Increase the numbers of CBOs conducting ACA informational sessions
a. Particular emphasis should be given to increasing the capacity of Minority CBOs (MCBOs) and Minority serving CBOs (MsCBOs) that target and effectively reach Black MSM.

Summary: The ACA provides Americans—including those at risk for and living with HIV/AIDS—better access to healthcare coverage and more health insurance options. This important policy ensures access to up-to-date treatment and services. The EtE should endeavor to: (1) improve access to coverage; (2) enhance the capacity of the healthcare delivery system; (3) ensure quality coverage. Particular emphasis should be given to increasing the capacity of MCBOs and MsCBOs that target and reach Black MSM.

#3 RANKED PRIORITY

BP23: PROMOTE COMPREHENSIVE SEX EDUCATION

New York State youth continue to have high rates of STIs which have serious health consequences including infertility and increased susceptibility to HIV infection. These rates are evidence that current school and family based efforts and approaches are not adequate. Since HIV transmission in New York is now almost exclusively sexually transmitted, New York State schools should be encouraged to provide comprehensive sexual health education. Such education deals not just with providing information on disease but tools for living healthily across the lifespan. This is similar to youth nutrition programs not only addressing the dangers of obesity but providing guidance on good food choices and exercise. Sexual health education, including LGBT sexual health, provides students with the knowledge, skills, and support they need to make healthy decisions, develop positive beliefs, and respect the important role sexuality plays throughout a person's life. At the secondary level, sexuality education includes the knowledge and skills to delay sexual activity and prevent and protect against sexually transmitted infections including HIV, unintended pregnancies, including the effective use condoms, contraceptives, nPEP, and PrEP. Education at all levels must be inclusive and respectful of the role gender identity and sexual orientation play in sexual health [CR38].

1. The comprehensive sex education curriculum should include age-appropriate, medically accurate information on a broad set of topics related to sexuality including human development, relationships, decision making, abstinence, contraception, and violence, disease prevention.

a. Establish NYS curricula standards that require annual comprehensive sex education that is inclusive of and culturally responsive to diverse student populations, including young Black MSM.
b. Design, develop and disseminate a sexual health curriculum that is inclusive of LGBTQ People of Color.
c. Ensure curricula are gender and culturally concordant as well as developmentally appropriate.
d. Increase utilization among out-of-school time (OST) participants

2. Expand use of/adapt existing developmentally appropriate HIV curricula used in NYC public Schools.
a. Increase utilization among OST participants
b. Insure aforementioned material are applicable to/for the vision impaired, hearing impaired and mobility impaired.

3. Advocate for local CBOs to conduct/facilitate comprehensive sex education trainings in public middle and high schools
a. In NYC, population of focus can be reached through:
i. Department of Youth & Community Development OST programs.
ii. Alternative Sentencing programs
b. Make information about sex education programming at local youth-serving CBOs available to schools.
***Note: This should include contracts with CBOs to delivery comprehensive sex education in K-12 and postsecondary schools, particularly schools in the SUNY system.

4. Update existing curricula to include biomedical interventions (PrEP, nPEP, TasP)

#4 RANKED PRIORITY

BP25: TREATMENT AS PREVENTION (TasP) AND ANTI-STIGMA MEDIA CAMPAIGN

New York State and the City of New York have a history of developing successful HIV-related public education campaigns. One model, the "HIV Stops with Me" campaign, is a statewide information effort targeting communities of high HIV prevalence to address stigma, discrimination and the prevention benefits of HIV treatment. A campaign that targets both HIV-infected and HIV non-infected individuals should promote prevention interventions and serve to improve treatment adherence for people living with HIV. Lowering the threshold for consent and access to treatment and ARV-P (antiretroviral prophylaxis) for adolescents at risk for HIV acquisition should be explored. Stigma has greatly impacted the ability of many members of affected communities to remain in care. A well-designed informational campaign targeting MSM of color, especially young Black MSM, recent immigrants (Latin American, Haitian, Caribbean and African immigrants in particular), transgender persons and cisgender women, may result in a significant increase in persons who access PrEP and nPEP, HIV testing, are linked to care, are retained in care and are adherent to ART. The campaign should also target health care providers to increase their cultural responsiveness skills and reduce the stigma that patients experience while in care. It should also increase the awareness and expanded use of new prevention options by health care providers. [CR42].

1. Increase utilization of marketing programs highlighting efficacy of ARV use (nPEP/PrEP/Treatment)
2. Information, education and communication (IEC) efforts should emphasize anti-stigma messaging.
    a. Messaging should be directed towards current communication channels preferred by the population of focus. (e.g., FB, Twitter, Tumblr, etc.)
3. IEC efforts should underscore that treatment is a process and that insurance facilitates that process.
4. IEC efforts should incorporate physicians, nurses and qualified health professionals to disseminate these messages.
5. NYSDOH/AI supported IEC efforts should get support/assistance from the Department of Education, Department of Justice and Department of Transportation.

Summary: From the start of HIV epidemic, the HIV-related stigma, discrimination and denial have fueled the transmission of HIV, impeding positive response to adequate care, support and treatment worldwide. An information, education and communication (IEC) campaigns is one of the most common cost-effective behavioral intervention strategies implemented so far to fight against HIV/AIDS.[5] The primary goal of such an IEC program is to inspire and educate people about prevention, care and/or treatment of HIV/AIDS and for a better understanding of HIV in a more comprehensive way.[6] Findings from prior research have indicated the usefulness IEC messages and materials in reducing stigmatizing and discriminatory attitudes towards people living with HIV.[7,8] Messages should be specific to the population of focus and use imagery and language that are culturally and gender concordant.

Existing HIV/AIDS related IEC materials are often insufficiently comprehensive or inadequately designed to local needs and issues. In many instances, print-based IEC materials are too lengthy, often repetitive, extremely generic, boring, outdated and even inaccurate at some places. The biggest concern is the poor translation of the materials from English to local language by non-professionals. Another problem identified is the lack of consistent collaboration and communication among organizations that deal with HIV/AIDS.

#5 RANKED PRIORITY

BP28: EQUITABLE FUNDING TO BE CLEARLY IDENTIFIED TO FOLLOW EPI-DATA

Equitable funding where resources follow the statistics of the epidemic: Since the early days of the HIV epidemic, certain populations have been much more heavily impacted than others. In the early 1990s, most diagnoses were related to injection drug use, while currently most new infections are among MSM, with specific concerns about young Black (including Black Latino) MSM. Additionally, diagnoses also varied from region to region, with some communities experiencing much higher HIV incidence than others. There is a need to work with agencies and providers who target these populations, and representatives of

[5] Drysdale R. Franco-Australian Pacific Regional HIV/AIDS and STI Initiative, Review of HIV/AIDS & STI, Information Materials, Report. September 2004. Available from: http://www.spc.int/hiv/index2.php?option=com_docman&task=doc_view&gid=50. [Last accessed on 2013 Nov 07}

[6] Ibid

[7] Chen J, Choe MK, Chen S, Zhang S. The effects of -individual-and community-level knowledge, beliefs, and fear on -stigmatization of people living with HIV/AIDS in China. AIDS Care 2007;19:666-73

[8] Peltzer K, Seoka P. Evaluation of HIV/AIDS prevention intervention messages on a rural sample of South African youth's knowledge, attitudes, beliefs and behaviours over a period of 15 months. J Child Adolesc Ment Health 2004;16:93-102

these communities to more effectively design and implement strategies for prevention, engagement, care and treatment. Resources should be dedicated to mobilizing community members to create new indigenous groups and networks to promote health and wellness goals and broader health care access. [CR24]

1. Ensure the process prioritizes funding to places where the population of focus resides.
    a. This would be consistent with the intent of the National HIV/AIDS Strategy
    b. Funding should focus on where the epidemic is and among organizations either indigenous to or having a significant history of serving Black MSM.
2. Ensure the funding process prioritizes funding indigenous organizations
    a. Pay attention to HIV incidence and geography
3. NYSDOH and other public health jurisdictions should provide technical assistance and capacity building assistance/development to indigenous Black MSM agencies to ensure effective/operational capacity for the dramatic shift to "medical/clinical" service provision.

Summary: There is a desire to convene public and private funders and discuss the direction and needs of the HIV epidemic as well as the organizational shifts required to meet changing needs. Perhaps a forum similar to Funders Concerned About AIDS (FCAA) or LGBTA Funders to host quarterly meetings with minority-run/minority serving CBOs. Resources to support equity in funding can include:

- Technical assistance to address emerging issues related to aligning funding with the changing dynamics of the HIV epidemic
- Capacity Building/Development to create or strengthen infrastructure for service delivery; emphasis should be added for indigenous organizations and coalitions.
- Bi-Annual review of funding should be compared to incidence and prevalence data while review prioritized populations and services.

NYS AIDS Advisory Council End the Epidemic Subcommittee: Black MSM Advisory Group

Blueprint Focus Area	End the Epidemic Task Force Strategies for "Get to Zero."

#1 RANKED PRIORITY

GTZ1 - SINGLE POINT OF ENTRY WITHIN ALL LOCAL SERVICES ACROSS NYS TO ESSENTIAL BENEFITS AND SERVICES FOR LOW INCOME PLWHA

1. Establish "coordination hubs" where Black MSM can be connected to a variety of health and human services.
2. Establish protocol to expedite process for approval and receipt of essential services and benefits (e.g., health insurance, housing assistance, medication assistance).
   ***NOTE: This should be based on epidemiological data on HIV care cascade outcomes for Black MSM and this has to be the highest priority population for access to essential benefits and services, including services to support/facilitate prevention.
3. Institute an inter-agency common registration process to support expedited access to services.
4. Require that grant funded organizations ensure that their clients who have multiple self-identified or provider-identified needs will be facilitated access to needed services/resources to support holistic approach to care and improved quality of life.
5. Develop and implement a quality assurance process to determine whether clients are linked to needed services are and followed-up appropriately.
6. Develop strategy for decentralizing and reducing access barriers to housing, food and travel vouchers.
7. Ensure access to housing, including single rooms or medically appropriate housing (not only emergency shelters).
8. Address and remedy source of income discrimination for housing.
9. Increase housing payment vouchers to levels that are in parity with other housing voucher programs.
10. Develop strategy for identifying asymptomatic Black MSM LWHA to get connected to housing and services. ***NOTE: Expansion of PATH strategies to jurisdiction across the State of New York
11. Housing support can be an access point to other benefits and services – depends on the organization where people go to for the services.
12. Train providers on the changes to HIV/AIDS Services Administration housing laws and who are eligible to receive services under the new regulations.
    ***NOTE: Expand to peer and caseworkers, navigators and other personnel who have routine frontline contact with consumers.

NYS AIDS Advisory Council End the Epidemic Subcommittee: Black MSM Advisory Group

#2 RANKED PRIORITY

GTZ6 - EXPANDING MEDICAID SERVICE TO TARGETED POPULATIONS AND FOR SEXUAL HEALTH AND DRUG TREATMENT RELATED SERVICES

1. Deliver community education on how to use insurance, including selecting plan and providers – insurance literacy programming.
2. Integrate expanded Medicaid eligibility screening into annual assessment and other front-line services (e.g. HIV testing) to increase the number of people who are aware of their eligibility for expanded Medicaid. This may include cross-training of staff to conduct eligibility screening and link to enrollment facilitators.
3. Increase the number of Medicaid eligible MSM signed up for expanded Medicaid and other insurance under ACA.
4. Support community programming, social marketing and other mechanisms for raising awareness regarding comprehensive health promotion and maintenance across the lifespan.
    a. For example, HPV vaccination, meningitis vaccination, anal health, anal pap smears, stress and mental wellness, safer substance use and implications for other substance use.
5. Incorporate health insurance and navigation literacy into group-level behavioral intervention models.
    ***NOTE: This strategy is designed to support utilization of insurance. A social network strategy approach can be used to have people who are engaged in the healthcare system to recruit and engage others in the healthcare system.
6. More clearly articulate the availability of outpatient substance abuse treatment services, including community education and social marketing to help people better understand what substance treatment services are covered by insurance programs.
7. Use a mobile app that can expand access to information regarding Medicaid eligibility, use and coverage. This should include a frequently asked question (FAQ) and live text component.
8. Support insurance coverage of family planning services for all cisgender and transgender men
9. Implement a consumer quality assessment system (e.g., YELP for HIV Care) that allows Black MSM and other consumers to rate their care and services, including consumer feedback that allows them to identify and endorse providers that they would recommend to others.

NYS AIDS Advisory Council End the Epidemic Subcommittee: Black MSM Advisory Group

#3 RANKED PRIORITY

GTZ7 - GUARANTEEING THE RIGHTS OF MINORS TO CONSENT TO HIV AND STI TREATMENT, DIAGNOSIS, PREVENTION AND PROPHYLAXIS INCLUDING SEXUAL HEALTH RELATED IMMUNIZATION.

1. Establish a system to alert health providers regarding changes in the law. Provide detailing to providers outside of HIV through professional health organizations, especially those whose members are likely to come in contact with minors.
2. Sponsor an annual medical symposium on MSM and HIV and other co-infections specifically for non-infectious-disease providers.
3. Support education of health care providers (nurses, social workers) and other professionals (e.g., teachers) who may work with youth regarding to know the updated regulations regarding sexual health.

#4 RANKED PRIORITY

[CR BP20]: ADDRESSING INCREASING PREVALENCE POLYSUBSTANCE USE AMONG BLACK MSM

1. Implement an anti-stigma campaign focused on polysubstance use disclosure and support from the Black MSM community and health system.
2. Identify outpatient and inpatient services using harm reduction models with emphasis on where Black MSM live and engage in substance use activities
3. Review the Substance Abuse and Mental Health Services Administration's (SAMSHA) National Registry of Evidence-based Programs and Practices (nREPP) to identify interventions to support substance use. NYS DOH should work with Office of Alcoholism and Substance Abuse Services to support integrated outcomes.
4. Support research to inform counseling strategies that can provide options for Black MSM to achieve sexual pleasure without dependence on substances.
5. Emphasize polysubstance use assessment and referral to relevant services among health and social service providers
6. Support research and evaluation to better understand the drivers of polysubstance use and to develop strategies to help Black MSM minimize impact of substance use on Black MSM's progress towards their prevention and treatment outcomes goals.

   ***Note: How can screening, brief intervention and referral to treatment (SBIRT) be adapted to other populations that can be referred to additional treatment, including using existing tools designed for polysubstance use and adapting for use in HIV service models.