MEETING AGENDA

Wednesday, October 23, 2019
2:30 p.m. – 4:30 p.m.

Call to Order

Welcome/Introductions

Approval of Agenda

Approval of Minutes

Report of Co-Chairs

Report of Staff

Discussion Items

- EHE
- Comprehensive Sex Education
- Update to Public Charge

Old Business

New Business

Announcements

Adjournment

PREVENTION COMMITTEE

Please contact the office at least 5 days in advance if you require special assistance.

The next Prevention Committee meeting will be held on
Wednesday, December 04, 2019 from 2:30 - 4:30 p.m. at the
Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107
(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

HIV Integrated Planning Council
Prevention Committee
September 25, 2019
2:30 PM – 4:30 PM
Office of HIV Planning 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Keith Carter, Mark Coleman, Dave Gana, Gus Grannan, Lorett Matus, Nhakia Outland, Lupe Diaz

Excused: Katelyn Baron, Janice Horan, Clint Steib

Absent: Erica Rand, Joseph Roderick

Staff: Briana Morgan, Nicole Johns, Sofia Moletteri

Call to Order:
L. Matus called the meeting to order at 2:40 PM.

Welcome/Introductions:
L. Matus skipped introductions since everyone in the group was familiar with each other.

Approval of Agenda:
L. Matus called for a motion to approve the September 25, 2019 Agenda. **Motion:** G. Grannan moved,
K. Carter seconded to approve the September 2019 agenda. **Motion passed:** general consensus.

Approval of Minutes *(August 28, 2019):*
L. Matus noted that on page 6, first paragraph and second sentence of the August 2019 minutes, there was the acronym EtE (Ending the HIV Epidemic) which was not defined before use. She proposed an amendment to the meeting minutes, dictating that EtE be defined before use. **Motion:** K. Carter moved, G. Grannan seconded to approve the July minutes. **Motion passed:** general consensus.

Report of Co-Chairs:
L. Matus had no report. She only reminded the committee that the November and December 2019 Prevention Committee meetings would not follow the regular schedule. In lieu of the two meetings, there would just be the one on December 4th. The meetings would return to the normal schedule in January 2020.

Report of Staff:
B. Morgan reported on the updates to the Service Directory page on the OHP (Office of HIV Planning) website. There were improvements made regarding navigability as well as mobile accessibility. From the homepage of the OHP website, go to the "find services" tab to get to the service directory page. She reminded everybody that there was a search bar to search zip code, language, service, etc. To get more information about a service, click on the name of the service.

She mentioned that people who work for or are engaged with an organization should check the directory for any misinformation and report it to info@hivphilly.org.

She also reported on a relaunch of the website blog. Thus far, there was a post about health equity and a profile on Dr. K. Moore who presented at the September 2019 Positive Committee meeting. She added that there would be a couple of posts about housing as well. Within a few weeks, the office would also distribute a revamped newsletter.

Last Thursday, September 19th, B. Morgan reported that she attended the HIV New Jersey Planning meeting. They discussed the change to the Public Charge rule and how it is affecting the way people access services. She said the committee would talk more about public charge later in the meeting.

Discussion Items:

—MSM Youth Healthcare—
Due to the recent topic of youth engagement, N. Johns decided to share the results and recommendations from 2014 focus groups OHP conducted with YMSM (young men who have sex with men).

To offer context, N. Johns mentioned the Lifetime Risk article from 2009. She noted that this article identified a risk projection that half of black MSM would have HIV by the age of 35. Because of this projected statistic, there was a rise in urgency.

The purpose of the study was to look with the PPG (prevention planning group) at some high-risk populations and to better understand engagement with and opinions on healthcare and HIV testing. Three service providers offered to host the focus groups, working with younger people mostly between 18 and 25. There was nobody under 18 years old, and there were about 10 people in each of the three focus groups.

OHP staff interviewed and held discussions with the groups, using prewritten transcripts for assistance and direction. N. Johns acknowledged that a limitation of the study was that focus groups are not generalizable to general population because of sample size. Most of the participating individuals graduated high school, some went to college, and all—except for one—were either Black, Hispanic, or both.

N. Johns said that socio-ecological factors of the structural, institutional/health system, community, interpersonal/network, and individual all effect healthcare and HIV risk and choices.

N. Johns listed themes that surfaced throughout the study: stigma, lack of comprehensive sexual health education, confidentiality and privacy concerns, distrust of the healthcare system and organizations, and cultural norms/gender norms. The themes came about by asking the group questions regarding emergency care, regular care, and appointment frequency. There were open ended questions as well as prompts that involved brainstorming. There was also a portion where participants rated services and explained the ratings. They describe what their ideal healthcare situation looked like. The ideal healthcare portion especially highlighted the issue around the courtesy and care from those in the front office.

N. Johns read a quote from a participant regarding why people do not get healthcare:

> "...but at the end of the day you can always tell when somebody's trying to be ignorant or shady, for lack of a better word; just treating you the wrong way. I think that if they stop doing that more people would be willing to come to the doctor and go get their medicine."

The previous quote, N. Johns explained, was specific to those with HIV and experiencing stigma. Some of the men who participated disclosed that they were HIV positive though they were not specifically asked. She said there are perceived layers of quality of care depending on a lot of different socio-ecological factors and identities/presentation. This often showed in the vast amounts of rude customer service. She mentioned two stories that participants shared wherein healthcare office staff publicly chastised individuals for being on Medicaid or getting an STI again.

N. Johns read three other quotes from participants that addressed why individuals may not link to healthcare:

> "Why they got to have a reason," "Sometimes it's a time management issue – when someone's working or going to school. So making sure their schedule is like ours," and "I felt like a huge road block with accessing health care is stigma, pride."

The acknowledgment of pride in the last quote referred to the cultural norm of men not accessing healthcare. Many participants mentioned that they helped other family members get healthcare even if they didn't themselves. The fear of stigma is a powerful barrier.

Participants were also asked about HIV testing locations. Luckily, everyone in the group knew a lot of places that offered testing. N. Johns said participants were asked to describe an acceptable testing site. One participant responded, "[t]o be honest with [the question], [they] would most likely go to [their] primary doctor, and/or the ER because of confidential reasons and judgment. [They] wouldn't feel comfortable with a heterosexual doctor asking [them] questions and/or just trying to get deep into [their] business. But [they] will actually go to a place that's very comfortable and open to everybody that comes."

The idea of inclusivity and affirming ideas was important to all of the participants. Going to regular care doctor for testing was preferable to going elsewhere because of the positive rapport and trust built up with a general practitioner.

K. Carter pointed out that there was a lot of assumption that all the doctors were straight. N. Johns said that if a provider is queer, that may be extremely beneficial; openness about queer identity could create a positive experience for the client. N. Johns mentioned how places that were serving LGBTQ+ individuals needed to be affirming and welcoming—for example, participants felt uncomfortable being labeled as "high risk."

Along with the unacceptable quote, N. Johns explained how there was also a question asking about unacceptable HIV testing. One participant's response was as follows:

"A lot of the places that were not selected, they have issues in customer service. Where individuals who attend those locations are made to feel less than. They're not greeted professionally. It's usually based upon attitude. Even if a consumer is coming to them with some attitude, they should be a little bit more professional – to treat them as a client or consumer, as opposed to a buddy."

The themes of kind customer service and confidentiality were apparent in responses. N. Johns reported that addressing people by their names, explaining wait times and keeping clients in the loop, respecting privacy, professionalism, comfortable waiting rooms, and answering the phone were all important to participants.

N. Johns listed unacceptable and acceptable testing site characteristics reported from the focus groups. Unacceptable included bad reputation, knowing people who worked there, unprofessional staff, and public testing settings. Acceptable testing sites included healthcare providers, LGBTQ-friendly organization, incentives offered, and a sexual health or HIV provider. She said that the incentives worked because they act as a "cover" for people. People could say that they're going to get tested for the incentive so they don't have to disclose that they might be at risk. L. Matus asked what a public setting might include. N. Johns said any pop-up public space would be considered a public testing site. B. Morgan said that it tied into the idea of being seen by people you know.

Confidentiality, as N. Johns noted previously, was a reoccurring issue within HIV care. One patient described the issue: "I know nowadays a lot of our peers are testing us. Somebody that I know tested me, and I'm like 'What if I test positive and then he'll know; because he knows basically everyone that I chill with or talk to.' People can't keep quiet." N. Johns explained how having peers do the work was positive for some, but not all. No one could give an example of a peer breaking confidentiality, but participants were still afraid of the potential breach of confidentiality.

N. Johns moved onto the recommendations portion of the study. She said that the recommendations came from participants in the focus groups, but, based on other studies, reoccurring themes for the focus groups seemed to be the same for similar populations.

The recommendations were as follows:

1) *Increasing access to and engagement with primary care for YMSM is essential.* N. Johns commented on how everyone experiences barriers to healthcare, but YMSM have to deal with many layers of stigma and more barriers than usual. B. Morgan mentioned how lack of experience navigating healthcare was also a barrier. N. Johns said that the participants had a lot of concern around healthcare navigation, because the focus group research took place during rollout of Obamacare. She said that the relationship with a good and considerate doctor was vital to increased engagement.

2) *A combination of routine testing in all primary care settings and targeted community-based testing is necessary.* N. Johns said that there was research in Atlanta that identified four types of testing behaviors in Black MSM. One group gets testing regularly, some only get tested under risk-based circumstances, others only get tested when it is convenient to them, and others are avoidant and do not get tested. The reasons for the avoidant group are many: e.g. fear of homophobia, stigma, being seen by others, etc. N. Johns explained that targeted testing helps people who aren't already engaged in healthcare begin the process.

3) *Comprehensive evidence-based sexual health education, inclusive of all gender identities and sexual orientations, is needed in the Philadelphia school district.* N. Johns noted that only one person felt like they had adequate sexual education. Many did not receive relevant or accurate health information. The focus groups reported that a lot of education was focused on avoiding pregnancy and was hetero-centric. K. Carter mentioned the Youth Behavior Survey and inquired about YMSM of color infection rates. B. Morgan said that infection rates were stable but still way higher than they should be. K. Carter asked where PA ranks in regards to sex education compared to other states.

N. Johns said it depends on the school—changing it would be a legislative push. Schools can individually teach more comprehensive sex education, but it is not required, so most do not. She did,

however, mention how participants received good and relevant information from some separate entities that came to the school for afterschool programs.

4) *HIV testing protocols should address concerns about confidentiality.* N. Johns said that being open and honest about confidentiality would put patients at ease.

5) *Special attention should be paid to creating welcoming and accepting organizational cultures.* She explained how diversity and inclusiveness was a top priority for all focus groups. Diverse and intergenerational care was valued in regards to services and employees alike. N. Outland asked if any of the people in the focus groups were fathers. For her organization, N. Outland mentioned how she was redoing intake form, and she noticed that a lot of men have kids. The reason this was such an important thing to note was because people generally assume that MSM do not have children. Therefore, childcare can be a barrier since they are not recognized to need related services. N. Johns agreed, saying that expanding the idea of who the caregivers are is important.

6) *Relevant information about local services, sexual health, and HIV/STD testing should be online in the places YMSM are likely to find it.* N. Johns noted that some places have the wrong address on their website. B. Morgan said that most businesses are listed on Google Maps, but organizations do not think to change it on there. This was problematic, because people often refer to Google Map for directions. N. Johns noted that people do not read brochures. Instead, people utilize online resources more. Accurate online information helps young people access healthcare and HIV resources. Online information can help to counter the lack in educational settings.

M. Coleman asked if people from Caribbean/African cultures have different issues with transmission or testing. N. Johns said that this focus group was YMSM who grew up in the EMA and especially Philadelphia. G. Grannan said that would be great information to research, especially since there is a healthy stream of immigration in Philadelphia. N. Outland mentioned M. Martinez and how she could be an excellent resource for such information.

7) *Community level efforts are needed to address HIV stigma and discrimination of LGBTQ individuals.* N. Johns explained that this specific recommendation was related to changing social norms, especially those existent within the African American community.

8). *Public health programs and healthcare organizations must be sensitive to the effects of stigma and discrimination on YMSM.* N. Johns explained how this final recommendation was often a topic of conversation, yet there are no policies or programs designed around this idea. She said that organizations need to find ways to incorporate it into their practices.

N. Johns emphasized the need for cultural competency. Cultural competency includes environments that are inclusive, respectful (use of eye contact, name), valuing privacy/confidentiality (and recognizing the difference between the two), sex positive (no shaming), treating patients as individuals, not as "risk populations (there is an existing partnership between patients and providers). She said that people should be making decisions together—a dialogue is needed. Trust leads to better healthcare.

N. Johns discussed the conclusions from the focus group. The first conclusion was that linkage to a supportive and informative provider is key to engagement in care. In other words, having an invested and caring provider helped, and it was important to have as few people as possible interacting with the patient's confidential information. The second conclusion was that young men care about their

health, but often have significant individual, social and provider-level barriers to overcome. The third conclusion recognized that simple changes to how clients/patients are treated could impact retention in care. In other words, respect was a key factor in the care continuum.

—Ending the HIV Epidemic—

B. Morgan reported a small update to the local EtE (Ending the HIV Epidemic) Plan update in which the CDC announced the starter grant ofunding. She said there was a handout in the meeting packet, so that the group could check the amfAR resource out more extensively later. She also noted that the acronym has been changed from EtE to EHE.

The amfAR website had information for the 48 counties and 7 states participating in EHE. B. Morgan noted that there is also data listed for other jurisdictions as well. She said the website included a lot of interesting information—deportation processes by ICE, criminalization/incarceration, and other data sets that might be more common. The website also offered information like location of syringe service programs and distance to nearest substance use provider offering MAT (Medication Assisted Treatment).

Though the most recent data was 2015, B. Morgan said it was all still very applicable. N. Johns asked if the data is only measured by state. B. Morgan said no, it depends on what you are looking to individually measure. For example, for RWHAP, providers can be broken down by county.

B. Morgan suggested everyone poke around the website to get a better understanding of where the EMA fits in a national context. She said that within the coming months, they will be looking at different jurisdictions EHE's plans. Therefore, referring to this website would be helpful.

—Public Charge—

B. Morgan noted that Public Charge was a significant topic at the recent HIV New Jersey Planning meeting. The NJ Planning Council saw Public Charge change a lot for providers and clients in NJ, specifically Newark. When the government evaluates immigrants for either green cards or visas, they assess whether the individual would be a "public charge" and cost the state money.

B. Morgan said that the public charge rule did not initially target those using essential health and nutrition programs—it only considered those who were "primarily dependent" on certain long-term benefits. However, the new rule would target those using Medicaid, SNAP (Supplemental Nutritional Assistance Program), food stamps, Public Housing and Section 8, and cash assistance. The drastic change in the rule has impacted the way immigrants are accessing healthcare. It is especially harming people who are living with disability, since Medicaid is the only way that many people can access disability programs.

She explained that Newark already noticed a decrease in those accessing healthcare, because people are afraid of not getting permanent status or losing their legal status and being deported. She said that when people are reviewed for immigration-related things, they are determined about how much they are a public charge. B. Morgan said that the problem is that there have been additions to the public charge rule. B. Morgan said the rule isn't supposed to be enforced in a way that impacts someone's family, but that will be possible.

N. Outland said that the "systems don't talk" in Philadelphia, so if people can access these services and nobody would know. N. Johns explained that the federal government has jurisdiction and can ask

for the information. G. Grannan agreed and said a lot of the programs are federal, so there aren't any privacy levels.

N. Outland asked about the timing for Public Charge. B. Morgan responded that it is very new, and N. Johns said it would be implemented on October 15, 2019. N. Johns said that RWHAP would not be considered in Public Charge, but facts may not matter since fear is driving people away from any sort of contact with healthcare. They do not want to take any chances. G. Grannan commented that RWHAP is a payer of last resort, so clients first have to go through Medicaid to get to RWHAP.

M. Coleman asked about immigrants' rights in the city of Philadelphia and confidentiality of information. N. Johns said that the city does not have to share information. L. Diaz agreed, saying that the city might not be complicit with this, but the other counties in the EMA are not in a sanctuary area and are going to be at risk.

G. Grannan said that he has done work with an immigration rights organization, and his organization had to do an astonishing amount of work to get even one database unplugged from the federal system. N. Johns said PA is not a sanctuary state, so anyone accessing a state funded program would not be "safe." B. Morgan agreed and said that anybody who costs the federal government money will have an issue finding any sort of service at all.

N. Outland said that even children who are natural born with an immigrant parent will be affected. N. Johns said that people are so driven by fear right now, and are afraid to take any risk because the consequences are so great. G. Grannan expressed concern around disease outbreaks in immigration communities and how they would not be addressed.

B. Morgan asked everybody to report back to the office if they hear anything from the communities impacted, providers, etc. She said that accessing information from impacted communities would be difficult, because there would not be a feedback loop—people would just be dropping out of the system.

N. Outland asked if there was any concise, informational handout that could be dispersed to the community. B. Morgan said that the office would look into it.

Old Business:

None.

New Business:

G. Grannan said that a second county in West Virginia had functionally gotten rid of their syringe exchange program. It was initially run out of the county Health Department in Clarksburg. He said there was an HIV outbreak in Huntington, WV as well as in the southern part of state. L. Matus asked if West Virginia was part of the EHE epidemic. G. Grannan said that Ohio and Kentucky were, but he was unsure about West Virginia. He said people should be aware and that there are only two pharmacies in the state that sell syringes without prescription. Still, he was not sure if even that was still true.

G. Grannan said that it is not a statewide policy, so in theory each county can choose their own legislation. However, it was unlikely that the legislation would change at all, since every county seems overall against the syringe exchange.

B. Morgan said that she was currently looking into information for people with a disability as well as HIV. She specified that this was not disability due to HIV. G. Grannan asked if she was only looking

into ADA (Americans with Disabilities Act) or disabilities in general. B. Morgan said any disability. N. Outland said there is a LGBTQ group for people with disability in Philadelphia that B. Morgan should look into.

Announcements:

K. Carter announced that he was leaving voting registration forms out on conference room table—he said that the deadline was October 5th, 2019.

L. Matus announced that this Friday, September 7th, would be National Gay Men's HIV Awareness Day.

N. Johns announced that the Comprehension Planning Committee meeting in October 2019 would hold a conversation around housing and Housing First / its feasibility in RWHAP. She said they will be looking at especially vulnerable populations. The committee would also look at HIV positive women who are pregnant or postpartum. She said the population that is small in size but particularly vulnerable. They would also look into other vulnerable populations such as people reentering the community after incarceration or other institutions. If anyone is interested or has important resources/information, N. Johns asked people to email her and come to the Comprehensive Planning meeting.

N. Outland announced that Outfest would be October 13th, 2019.

L. Matus announced that October 15th would be National Latino AIDS Awareness Day and October 20th would be AIDS Walk.

N. Outland announced that she would be teaching a course on October 19th about adopting sex positive approaches in LGBTQ sexual health. The course would be at Temple University. To register, go to the Temple website and then noncredit courses.

M. Coleman announced that absentee ballots should be online until October 31st.

Adjournment:

Meeting adjourned at 4:12 PM by general consensus.

Respectfully Submitted,

Sofia M. Moletteri, staff

Handouts distributed at the meeting:

- September 2019 Prevention Committee Meeting Agenda
- August 28, 2019 Prevention Committee Meeting Minutes
- Experiences in HIV Testing and Health Care in Philadelphia for YMSM
- Ending the HIV Epidemic Database
- Public Charge: A Threat to Immigrant Families

P. MICHAEL STURLA, CHAIRMAN
414 MAIN CAPITOL BUILDING
P.O. BOX 202096
HARRISBURG, PENNSYLVANIA 17120-2096
(717) 787-3555
FAX: (717) 705-1923

HOUSE DEMOCRATIC POLICY COMMITTEE

WEBSITE: www.pahouse.com/policycommittee
EMAIL: policy@pahouse.net
@PADemPolicy

House of Representatives
COMMONWEALTH OF PENNSYLVANIA

HOUSE DEMOCRATIC POLICY COMMITTEE HEARING
Topic: Comprehensive Sex Education
Thomas Jefferson University– Philadelphia, PA
October 17, 2019

AGENDA

2:00 p.m. Welcome and Opening Remarks

2:10 p.m. Panel One:
- Melissa Weiler Gerber, President & CEO, AccessMatters
- Aletha Akers, MD, MPH, FACOG, Medical Director of Adolescent Gynecology Consultative Services, The Children's Hospital of Philadelphia
- Lynette Medley, MEd, Founder/CEO, No More Secrets Mind Body Spirit Inc.
- Carlee Warfield, Student, Downingtown STEM Academy

2:30 p.m. Questions & Answers

2:45 p.m. Panel Two:
- Miciah Foster, SistahSpeak! Youth Project Coordinator, New Voices for Reproductive Justice
- Dr. Amanda Micucio, DO, FAAP, General Pediatrician and Clinical Assistant Professor at Sidney Kimmel Medical College of Thomas Jefferson University
- Patricia Fonzi, President & CEO, Family Health Council of Central PA
- Michelle Schamis, Artist and Mother of Transgender Teen

3:00 p.m. Questions & Answers

3:20 p.m. Panel Three:
- Zaakirah Hamid, Sexual Health Educator, Planned Parenthood SEPA
- Alma Sheppard-Matsuo, Teacher/GSA Advisor, Dobbins Technical High School
- Elicia Gonzales, LSW, MEd, Executive Director, Women's Medical Fund
- Tillie Donover, Alumnus, Philadelphia School District

3:35 p.m. Questions & Answers

3:50 p.m. Closing Remarks

House Co-Sponsorship Memoranda

House of Representatives
Session of 2019 - 2020 Regular Session

MEMORANDUM

Posted: February 13, 2019 12:56 PM
From: Representative Brian Sims and Rep. Mary Jo Daley
To: All House members
Subject: Sex Education and Affirmative Sexual Consent

Despite declines in teen pregnancy rates in recent years, teen births in the United States are still high compared to many other developed countries – there are 20.3 births per 1000 females aged 15 to 19. By comparison, there is an average of 12.7 births per 1000 females in that age range for all Organisation for Economic Co-Operation and Development countries, which includes a diverse range of 36 nations from Finland to Costa Rica. Further, people under the age of 25 account for about half of new cases of sexually transmitted infections (STIs) each year. These statistics, startling for a country of our economic status, mean we have to do more to keep our young people healthy and safe from the unintended consequences that can come from sexual activity.

Comprehensive sex education needs to be part of the solution. The Centers for Disease Control and Prevention (CDC) has reported that "comprehensive sex education programs have been shown to reduce high-risk sexual behavior, a clear factor for sexual violence victimization and perpetration." In addition, several studies found that comprehensive sex ed increases positive sexual behaviors in teens.

That is why we are introducing legislation to require school districts to teach age-appropriate comprehensive sex education to all grade levels, including concepts such as "good touch vs. bad touch" for elementary school students and contraception methods for older students. Further, my legislation would mandate affirmative sexual consent as part of the required sexual violence awareness educational program at institutions of higher education. It is our belief that this legislation will help children identify and avoid risky sexual behaviors and negative relationships, ensuring they become healthy adults. This legislation might also help us avoid increases to healthcare costs related to teen pregnancy and STIs.

Your consideration and co-sponsorship are appreciated.

Introduced as HB1586

PRINTER'S NO. 2034

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1586 Session of 2019

INTRODUCED BY SIMS, DALEY, RABB, SCHLOSSBERG, DONATUCCI, BURGOS, KINSEY, A. DAVIS, SOLOMON, ISAACSON, McCLINTON, HILL-EVANS, KIRKLAND, BRIGGS, KRUEGER, FRANKEL, COMITTA, CEPHAS, DAWKINS, HOHENSTEIN, MADDEN, ROZZI, FITZGERALD, YOUNGBLOOD, STURLA, SHUSTERMAN AND OTTEN, JUNE 6, 2019

REFERRED TO COMMITTEE ON EDUCATION, JUNE 6, 2019

AN ACT

1 Amending the act of March 10, 1949 (P.L.30, No.14), entitled "An
2 act relating to the public school system, including certain
3 provisions applicable as well to private and parochial
4 schools; amending, revising, consolidating and changing the
5 laws relating thereto," in terms and courses of study,
6 providing for sexual health education; in sexual violence
7 education at institutions of higher education, further
8 providing for education program; and imposing duties on the
9 Department of Education and the Department of Health.

10 The General Assembly finds and declares as follows:

11 (1) Discussions between youth and their parents or
12 guardians is the most important way to help youth make
13 responsible and healthy life decisions.

14 (2) However, Pennsylvania's schools and other community
15 groups also have a responsibility to help ensure that the
16 youth have the knowledge and skills necessary to enable them
17 to make informed life decisions, to protect their health, to
18 prevent unintended pregnancy and to reduce the risk of
19 sexually transmitted infections (STIs).

20 (3) Research has identified highly effective sex

1 education and HIV prevention programs that positively affect
2 multiple behavioral outcomes and achieve positive health
3 impacts, which include the delay of sexual activity, a
4 reduction in the frequency of sex, the number of partners and
5 the incidence of unprotected sex and an increase in use of
6 condoms and contraception among sexually active participants.
7 Long-term outcomes and impacts include lower STI and
8 unintended pregnancy rates.
9 The General Assembly of the Commonwealth of Pennsylvania
10 hereby enacts as follows:
11 Section 1. The act of March 10, 1949 (P.L.30, No.14), known
12 as the Public School Code of 1949, is amended by adding a
13 section to read:
14 Section 1512.2. Sexual Health Education.--(a) Each school
15 shall provide students with sexual health education that meets
16 the following criteria:
17 (1) Information presented is medically accurate and
18 evidence-based, including, but not limited to:
19 (i) The effectiveness, safety, proper use, health benefits
20 and side effects of all contraceptive methods approved by the
21 Food and Drug Administration for preventing unintended
22 pregnancy.
23 (ii) Information about sexually transmitted infections
24 (STIs), including how STIs are and are not transmitted and the
25 effectiveness of various risk-reducing strategies, including
26 medication approved by the Food and Drug Administration such as
27 preexposure prophylaxis (PrEP) medication and postexposure
28 prophylaxis (PEP) medication.
29 (2) Instruction and materials:
30 (i) Are age-appropriate.

1 (ii) Include the following information:
2 (A) The anatomy and physiology of the human body,
3 particularly as it relates to human reproductive organs and
4 functions.
5 (B) The benefits of and reasons for delaying sexual
6 activity.
7 (C) That not engaging in sexual activity is the only
8 completely reliable way to prevent pregnancy and to reduce the
9 risk of contracting STIs, including HIV.
10 (D) The effect of alcohol and drug use on decision making
11 and partner communication.
12 (E) The importance of healthy relationships that are based
13 on mutual respect and open communication.
14 (F) Relevant elementary education topics such as friendship,
15 body parts, puberty and "good touch versus bad touch."
16 (G) Up-to-date information on available local resources for
17 sexual and reproductive health care, including how to access the
18 resources and the legal rights afforded to individuals accessing
19 the resources and resources available for victims of sexual
20 harassment or assault.
21 (H) Up-to-date contact information for the school's Title IX
22 Coordinator.
23 (iii) Address healthy relationships and social pressures
24 related to sexual behaviors.
25 (iv) Establish an affirmative consent standard that includes
26 the following information:
27 (A) Both parties are responsible for obtaining affirmative
28 consent before proceeding with any sexual activity, including
29 between individuals who have previously engaged in sexual
30 activity with one another.

1 (B) The absence of protest or resistance does not constitute
2 affirmative consent.
3 (C) Past sexual relations and existing relationships are not
4 indicative of affirmative consent.
5 (v) Emphasize the dangers and risks of sexting. The emphasis
6 shall include the following information:
7 (A) Images are easily shared and can be made publicly
8 available online.
9 (B) Once distributed online, images can be difficult to
10 remove.
11 (C) Consequences of sexting may include charges of criminal
12 activity, such as child pornography and disseminating of
13 indecent material to minors.
14 (vi) Discuss sexual activity as it relates to risk for STIs
15 and unintended pregnancy.
16 (vii) Encourage students to communicate with parents,
17 guardians, health care providers and other youth-serving or
18 trusted adults about sexuality without jeopardizing the
19 student's safety and well-being.
20 (viii) Are inclusive and do not promote bias against
21 students, regardless of race, religion, national origin, gender,
22 gender identity, gender expression, sexual orientation, sexual
23 expression or disability.
24 (3) Instructors are permitted to answer in good faith any
25 questions initiated by students that are germane to the material
26 of the course.
27 (b) (1) If the parent or guardian of a student under 18
28 years of age provides a written request to the school that the
29 student be excused from all or any part of sexual health
30 education, the student shall be excused from all or any part of

1 the sexual health education required under subsection (a) and
2 may not be subject to disciplinary action or academic penalty
3 for not participating in sexual health education instruction.
4 (2) The following shall be made publicly available to
5 students, parents and guardians through the school district's
6 publicly accessible Internet website, if available, the school
7 district's student manual or by other means of communication
8 currently used by the school district:
9 (i) information about the school district's sexual health
10 education instruction, including curriculum, information being
11 provided to students and a list of written and audio-visual
12 materials used for the education; and
13 (ii) a form for excusing a student under 18 years of age
14 from all or any part of sexual health education.
15 (c) The Department of Education, in consultation with the
16 Department of Health, shall develop and maintain a list of
17 sexual health education curricula consistent with the
18 requirements of this section. The list shall be updated at least
19 annually and made available on the Department of Education's
20 publicly accessible Internet website. The Department of
21 Education shall promulgate rules necessary to provide oversight
22 and to implement and administer the provisions of this section.
23 (d) Money appropriated by the General Assembly for sexual
24 health education shall not contravene the provisions of this
25 section and may not be used for health education programs that:
26 (1) withhold health-promoting or lifesaving information
27 about sexuality related topics, including HIV;
28 (2) are medically inaccurate or have been scientifically
29 shown to be ineffective;
30 (3) promote gender or racial stereotypes and biases;

1 (4) are insensitive or unresponsive to the needs of sexually
2 active young people, survivors of sexual violence, youth of all
3 physical, developmental and mental abilities or youth of all
4 gender identities, gender expressions or sexual orientations; or
5 (5) are inconsistent with the ethical imperatives of
6 medicine and public health.
7 (e) (1) Local school districts shall approve and select
8 curricula, textbooks and instructional materials from the list
9 maintained by the Department of Education under subsection (c).
10 (2) The curricula selected must be consistent with the
11 educational criteria required under subsection (a).
12 (f) Each school shall include comprehensive sexual education
13 training within the professional education plan under section
14 1205.1 and continuing professional education program under
15 section 1205.2 for teachers certified to teach health and sexual
16 education.
17 (g) Nothing in this section shall limit a student's ability
18 or right to seek or have access to counseling services.
19 Notwithstanding any other provision of this section, a parent or
20 guardian may not opt out a student from counseling services.
21 (h) As used in this section, the following words and phrases
22 shall have the meanings given to them in this subsection:
23 (1) "Affirmative consent" shall mean an affirmative, willing
24 and conscious ongoing agreement between both parties of legal
25 age to engage in sexual activity.
26 (2) "Age-appropriate" shall mean topics, messages and
27 teaching methods suitable to particular ages or groups of
28 children and adolescents, based on developing cognitive,
29 emotional and behavioral capacity typical for the age or age
30 group.

1 (3) "Comprehensive sexual education" shall mean instruction
2 which:
3 (i) addresses the physical, mental, emotional and social
4 aspects of human sexuality;
5 (ii) is designed to motivate and assist students in
6 maintaining and improving their sexual health, preventing
7 disease and reducing sexual health-related risk behaviors; and
8 (iii) enables and empowers students to develop and
9 demonstrate sexual health-related knowledge, attitudes, skills
10 and practices that are age-appropriate.
11 (4) "Gender expression" shall mean the expression of an
12 individual's gender, which may be through behavior, clothing,
13 haircut or voice and may not conform to socially defined
14 behaviors and characteristics typically associated with being
15 either masculine or feminine.
16 (5) "Gender identity" shall mean the internal sense of an
17 individual regarding whether the individual is female, male, a
18 combination of male and female, neither, or another gender
19 altogether, regardless of the individual's designated sex at
20 birth or gender expression.
21 (6) "Healthy relationship" shall mean an interpersonal
22 relationship that is based on mutual respect and open
23 communication and is free of physical abuse, sexual abuse,
24 emotional abuse, coercion and violence.
25 (7) "Inclusive" shall mean sexual health education
26 curriculum which ensures that students from historically
27 marginalized communities are reflected in classroom materials
28 and lessons.
29 (8) "Medically accurate" shall mean information supported by
30 peer-reviewed research conducted in compliance with accepted

1 scientific methods and recognized as accurate by leading
2 professional organizations and agencies with relevant
3 experience, including the American Medical Association and the
4 Department of Health.
5 (9) "School" shall mean any public school, including a
6 charter school or cyber charter school, intermediate unit or
7 area vocational-technical school operating within this
8 Commonwealth.
9 (10) "Sexting" shall mean the procurement or distribution of
10 sexually explicit photographs or messages via electronic means
11 such as a cell phone.
12 (11) "Sexual health" shall mean a state of physical, mental
13 and social well-being in relation to sexuality, requiring a
14 positive and respectful approach to sexuality and sexual
15 relationships that are free of coercion, discrimination and
16 violence.
17 (12) "Sexual orientation" shall mean an individual's
18 attraction, including physical and emotional attraction, to
19 other people of the same gender, a different gender or all
20 genders.
21 (13) "STIs" Shall mean an infectious disease that spreads
22 from person to person during sexual contact.
23 Section 2. Section 2003-G(a)(2) of the act is amended to
24 read:
25 Section 2003-G. Education program.
26 (a) General rule.--Institutions of higher education and
27 private licensed schools shall establish a sexual violence
28 awareness educational program. Institutions of higher education
29 and private licensed schools may collaborate with a Statewide
30 nonprofit organization, local rape crisis center or local sexual

1 assault program that arranges for the provision of services to
2 sexual violence and rape victims in the development of a sexual
3 violence awareness education program. Each education program
4 shall provide the following:
5 * * *
6 (2) A discussion of affirmative sexual consent,
7 including [an explanation that the victim is not at fault]
8 the information contained in the affirmative consent standard
9 under section 1512.2(a)(2)(iv).
10 * * *
11 Section 3. The addition of section 1512.2 of the act shall
12 apply to school years beginning after the effective date of this
13 section.
14 Section 4. This act shall take effect in 90 days.

New "public charge" rule will put immigrants' health at risk

OCTOBER 23, 2019

Tanya Albert Henry
Contributing News Writer
American Medical Association

If the government is allowed to go forward with a sweeping expansion of the criteria that determine which immigrants are considered a "public charge," the new definition will wreak havoc on the health of already vulnerable immigrant children, pregnant women and the disabled, physicians told a federal court.

The Litigation Center of the American Medical Association and State Medical Societies has joined the Washington State Medical Association and several other physician organizations in filing an amicus brief in the U.S. District Court for the Eastern District of Washington. They are urging the court to issue the preliminary injunction that is being sought by the state of Washington officials to stop the new regulation.

"Immediate and irreparable harm ... will impact millions of vulnerable individuals" if the court does not issue the injunction to halt the Department of Homeland Security (DHS) regulation's enforcement, says the brief, filed in the case of *State of Washington v. United States Department of Homeland Security*.

Without an injunction against the regulation, there is a bigger likelihood that lawful immigrants and their families will not seek health and nutrition benefits they are entitled to because of fear that doing so would hurt their immigration status, the brief says.

"Though DHS claims the regulation is intended to promote self-sufficiency, there is no evidence that chilling the use of health and nutrition benefits will result in an increase in income, employment or educational status of immigrants," the brief says. "These sweeping and detrimental changes will ultimately result in far greater costs to the public's health than any purported benefit offered by DHS."

The case is one of a dozen lawsuits regarding the controversial rule. In October, Judge George Daniels of the U.S. District Court in Manhattan issued a preliminary nationwide injunction blocking implementation of the rule. Read the judge's opinion in the case, for which the AMA also filed an amicus brief.

What changed?

DHS in August promulgated a regulation that dramatically altered what immigration officials consider when evaluating whether a person seeking to immigrate will be deemed a "public charge." The new definition also could lead to the government

adjusting an immigrant's status. If an immigration officer concludes an immigrant is a public charge, the government can deem the immigrant inadmissible to the country.

Previously, a public charge was someone who would likely become primarily dependent on the government. For example, someone who received cash assistance or someone institutionalized in a government-funded long-term care facility.

Now, DHS defines a public charge as an immigrant "who receives one or more public benefits ... for more than 12 months in the aggregate within any 36-month period." If someone receives two benefits in one month, that counts as two months. The regulation also expanded "public benefits" to include health, nutrition and housing programs such as nonemergency Medicaid for nonpregnant adults and the Supplemental Nutritional Assistance Program (SNAP).

How will it hurt immigrants?

A May 2019 study from the Urban Institute—issued before the DHS rule had been made final—found that one in seven adults in immigrant families already reported avoiding noncash public benefits over the past year because they feared that doing so would harm their legal immigration status.

Survey results included in the study, "One in Seven Adults in Immigrant Families Reporting Avoiding Public Benefit Programs in 2018," showed that low-income members of immigrant families reported even higher avoidance rates:

- 46% reported opted against SNAP benefits.
- 42% decided not to seek medical benefits such as Medicaid and the Children's Health Insurance Program (CHIP).
- 33% avoided public housing subsidies.

"It is expected that the rates of avoidance will be markedly higher" once the new DHS rule is enforced, the AMA Litigation Center brief tells the court.

That will result in children losing health insurance coverage, likely contributing to deaths and future disabilities. And the brief notes that access to health insurance increases a child's likelihood of graduating high school and attending college.

With fewer people seeking SNAP assistance, children will not have access to nutritional food that "is fundamental to the health development of all children," the brief tells the court. That matters because "children in immigrant families that receive SNAP benefits are more likely to be in good or excellent health, be food secure and reside in stable housing."

The regulation will have similar damaging effects on pregnant women, as well as the disabled. Prenatal care results in fewer low birth weight babies and newborn deaths. For the disabled, access to Medicaid is critical to helping ensure they can attend school and work, the AMA Litigation Center brief tells the court.

https://www.ama-assn.org/delivering-care/population-care/new-public-charge-rule-will-put-immigrants-health-risk

Federal Judges In 3 States Block Trump's 'Public Charge' Rule For Green Cards

October 11, 2019 2:56 PM ET

By Laurel Wamsley, Pam Fessler, and Richard Gonzales

Updated at 9:27 p.m. ET
Federal judges in three states — New York, California and Washington — have issued temporary injunctions against the Trump administration's "public charge" rule, preventing it from taking effect on Oct. 15.
The controversial rule would make it more difficult for immigrants to get green cards if it looks as though they might need public assistance. Titled "Inadmissibility on Public Charge Grounds," the rule sparked several legal challenges.

Under the rule, U.S. immigration officials who decide whether an immigrant should be granted a green card would weigh whether the applicant will be self-sufficient. Among the factors the officials would use is whether the applicant is already using public benefits like food stamps, housing subsidies and cash assistance.

Judge George B. Daniels, of the Southern District of New York, ruled on Friday afternoon that the plaintiffs — five organizations that work to aid immigrants, as well as the governments of New York state, New York City, Connecticut and Vermont — are likely to succeed in their claims against the Trump administration.

"The Rule is simply a new agency policy of exclusion in search of a justification," Daniels wrote as he granted the request. "It is repugnant to the American Dream of the opportunity for prosperity and success through hard work and upward mobility. Immigrants have always come to this country seeking a better life for themselves and their posterity. With or without help, most succeed."

The rule, which the administration announced this summer, is being challenged in several federal courts by immigrant rights groups and more than a dozen state attorneys general. Opponents argue that it discriminates against low-income immigrants and immigrants of color by imposing tough new standards on those seeking legal permanent residency in the United States. They note that the public charge policy has been in place for over a century but the new requirements would favor wealthier immigrants.

By the end of the day, two other federal judges issued rulings against the Trump administration.

In California, U.S. District Judge Phyllis Hamilton ruled that Trump administration officials "acted arbitrarily and capriciously during the legally-required process to implement the changes they propose" in violation of the Administrative Procedure Act.
She also said the Department of Homeland Security failed to adequately consider the costs to local and state governments when immigrants leave public health benefit programs. For example,

Hamilton said that the government, in legal briefs, minimized the potential public-health consequences of the proposed rule.

"It made no attempt, whatsoever, to investigate the type or magnitude of harm that would flow from the reality which it admittedly recognized would result—fewer people would be vaccinated," Hamilton wrote.

The ruling follows a suit brought by California, Maine, Oregon, Pennsylvania and the District of Columbia.

In Washington, U.S. District Judge Rosanna Malouf Peterson issued a nationwide injunction ruling that DHS had "not cited any statute, legislative history, or other resource that supports the interpretation that Congress has delegated to DHS the authority to expand the definition of who is inadmissible as a public charge or to define what benefits undermine, rather than to promote, the stated goal of achieving self-sufficiency."
The ruling comes in a suit brought by the state of Washington and 13 other states: Virginia, Colorado, Delaware, Hawaii, Illinois, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico and Rhode Island.

The White House issued a statement late Friday expressing its disappointment with the rulings, especially the nationwide injunction.

"The rulings today prevent our Nation's immigration officers from ensuring that immigrants seeking entry to the United States will be self-sufficient and instead allow non-citizens to continue taking advantage of our generous but limited public resources reserved for vulnerable Americans," the statement read. "These injunctions are the latest inexplicable example of the Administration being ordered to comply with the flawed or lawless guidance of a previous administration instead of the actual laws passed by Congress. "

Under the new rule, immigration officials would consider a number of factors when deciding whether someone should be denied a green card because they might become a public charge, or burden, on society.

For example, if people earn less than 125 percent of the poverty level, that would be held against them. If they can't speak English or have large debts, that would also count against them. If they use food stamps, housing assistance or Medicaid, that too would be held against them.

The Trump administration argues that the rule is only clarifying existing law, saying it believes immigrants who want to stay in the U.S. should be able to support themselves and not rely on government aid. The administration also argues that safety-net programs are needed to aid U.S. citizens and there is not enough money to provide additional benefits.

Ken Cuccinelli, the acting director of U.S. Citizenship and Immigration Services, summarized the administration's position on NPR's *Morning Edition* by paraphrasing the Emma Lazarus poem on the base of the Statue of Liberty.

Cuccinelli, who is named in the lawsuit, said the inscription should read instead: "Give me your tired and your poor who can stand on their own two feet and who will not become a public charge."

In a statement Friday, Cuccinelli responded to the temporary injunction:

"Long-standing federal law requires aliens to rely on their own capabilities and the resources of their families, sponsors, and private organizations in their communities to succeed. The public charge regulation defines this long-standing law to ensure those seeking to come or stay in the United States can support themselves financially and will not rely on public benefits. Through faithful execution of the law, we will ensure immigrants are able to successfully support themselves as they seek opportunity here. An objective judiciary will see that this rule lies squarely within long-held existing law."

Advocates for immigrants cheered the Judge Daniels' move. "Today's decision marks a major defeat for the Trump administration's unlawful tactic to impose a racist wealth test on our immigration system," said Javier Valdés, co-executive director at Make the Road New York, which was among the plaintiffs, in a statement. "People should be able to access vital and life-saving benefits without having to worry if they could remain with their families. We will continue to stand up to this administration's onslaught on immigrants and people of color—we will fight and protect our communities from inhumane policy changes every step of the way."

Confusion around the new policy has spurred many immigrants to drop benefits unnecessarily, even before the rule was set to take effect. Opponents say the administration's proposed rule could have a devastating impact on public health and impose huge costs on local and state governments.

A study by the Urban Institute found that 1 in 7 adults in immigrant families avoided participating in a public benefit program in 2018 owing to fear of risking future green card status.

The rule is just one in a series of efforts by the White House to limit both legal and illegal immigration to the U.S.

Last week, President Trump signed a proclamation barring the entry of legal immigrants who cannot prove they will have health care coverage or the means to pay for it within 30 days of their arrival in the U.S. Under that proclamation, starting Nov. 3, only immigrants who can show they can pay for "reasonably foreseeable medical costs" or are already covered by approved health insurance would be allowed to enter the U.S.