Philadelphia HIV Integrated Planning Council
Prevention Committee
Meeting Minutes of
Wednesday, June 30, 2021
2:30-4:30 p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: David Gana, Gus Grannan, Kailah King-Collins, Lorett Matus (Co-Chair), Clint Steib (Co-Chair), Desiree Surplus, Adam Williams

Guests: Brian Hernandez (AACO), William Pearson (AACO), Javontae Williams (AACO), Vanessa Whitt

Excused: Debra D'Alessandro, Keith Carter

Staff: Beth Celeste, Debbie Law, Mari Ross-Russell, Sofia Moletteri, Julia Henrikson

Call to Order: L. Matus called the meeting to order at 2:36 p.m. She said that the allocations meeting went smoothly. She thanked everyone for attending today and was glad they could now pick up where they left off.

Welcome/Introductions: C. Steib asked that everyone begin to introduce themselves. J. Williams said he invited individuals from the Prevention Team at AACO.

Approval of Agenda: C. Steib presented the August 2021 Prevention Committee agenda for approval. **Motion**: D. Gana motioned, G. Grannan seconded to approve the August 2021 agenda. **Motion passed**: 78% in favor, 22% abstaining.

Approval of Minutes (*June 30, 2021*): C. Steib presented the previous meeting's minutes for approval. **Motion**: D. Gana motioned, G. Grannan seconded to approve the June 2021 meeting notes. **Motion passed**: 60% in favor, 40% abstaining.

Report of Co-Chair:
None.

Report of Staff:
J. Henrikson reported that the group would soon be look into the Consumer Survey process. They would review the 2017 survey and update and revise questions. EHE (Ending the HIV Epidemic) and NHAS (HIV National Strategic Plan) would impact the types of questions they would discuss. A. Williams asked where they could access the prior report. S. Moletteri reported that the 2017 Consumer Survey was on the OHP website under the "Data and Statistics" tab. The attached document on the website had a summary and analysis of the survey with the survey questions at the end of the document.

S. Moletteri reported that there would be an OHP newsletter coming out soon. It would include information about the upcoming SYNChronicty 2021 Conference, the PENN CFAR Red Ribbon, and other upcoming events.

Discussion Item:

—Draft Letter to the Recipient—

J. Henrikson explained that during the last meeting, the group decided that crafting a letter to the recipient would be most powerful for the recommendations they previously crafted, specifically #1-3. They had discussed potentially including them in the allocations process, but they eventually decided to craft a letter to the recipient, separate from allocations. In Prevention Committee's last meeting, they approved the recommendation language, the language was sent to Executive Committee, and the Executive Committee approved the language as well. HIPC would also need to look at the language.

Though HIPC had not yet approved the recommendation language, in the interest of time, OHP created a draft of a possible letter. The letter was crafted by OHP staff by using language from Prevention Committee discussions and the recommendations, themselves. The committee could approve the language as a final draft, make corrections and ask C. Steib and L. Matus to approve it for September's HIPC meeting, or they could review it again as a committee in October.

J. Henrikson asked if they wanted to read through it. C. Steib said he had reviewed the letter, and from his perspective, it looked good. One part that confused him, however, was the sentence which included the NHAS acronym—he was confused since he heard it referred to as something else. J. Williams said NHAS was what the plan used to be called, but they changed it to HNSP (HIV National Strategic Plan). They changed this this to include "HIV" first so it mirrored the nomenclature for the STI and Hepatitis plans. D. Gana said he read through the plan and felt that it aligned with what they had discussed as a committee.

A. Williams asked what had happened to item #4 in the recommendations list from Prevention. In the May 2021 meeting, J. Henrikson said, the committee decided that #4 was an advocacy-related item and could not be included in their recommendations. They wanted to figure out another way to tackle this separate from any recommendations to AACO. C. Steib asked if everyone was okay with the letter and if they should vote to send it to HIPC.

J. Henrikson said they could vote on it, unless they wanted to make any edits. If they wanted to change the language, they should first discuss this. She said she could make the one alteration to change NHAS to HNSP. J. Henrikson said she would change this throughout the letter. A. Williams asked if they should be specific about the source of the HIV test. They wondered if there would be confusion regarding availability of the resources, so this could be the opportunity to point out that there were AACO resources. J.Williams said there was a self-test program for Philadelphia residents. C. Steib asked if there was a specific, approved take-home test from a certain manufacturer. J. Williams said AACO had a contract, so they used a specific test that they ordered in bulk. They also had a list of CBO partners that helped to distribute tests.

Motion: A. Williams motioned for unanimous consent to adopt the language with the discussed edits within the letter to AACO, D. Gana seconded. S. Moletteri said there would now be discussion on the motion, and if there was none, they would take a roll call vote. G. Grannan asked for an amendment to the motion to change it to "general consensus" over "unanimous consent," since this is usually how they held a vote. **Amendment:** A. Williams agreed to the amendment, replacing "unanimous consent" with "general consensus," D. Gana seconded. C. Steib asked if he and L. Matus needed to abstain as co-chairs. M. Ross-Russell said no, it was not completely necessary within the committees for them to abstain. She added that when something was coming from a particular group or individual, there would need to be someone who would initial or sign off on the letter. J. Henrikson noted that the end of the letter signified that it was submitted by HIPC a whole.

S. Moletteri asked if it would need signatures from L. Matus and C. Steib before it was presented to HIPC or after. M. Ross-Russell said that it would not need signatures from HIPC, but they would have to figure out "who" would have to sign the letter before it went to AACO. L. Matus and C. Steib said they would sign the letter if they needed. J. Henrikson said HIPC could also alter the language, because Prevention Committee was only presenting a draft, not the final language.

Vote:

L. Matus: in favor
A. Williams: in favor
D. Gana: in favor
D. Surplus: in favor
K. King-Collins: in favor
G. Grannan: in favor
C. Steib: in favor

Motion passed: 7 in favor, 0 abstaining, 0 opposed.

J. Henrikson said she would edit the letter to change NHAS to HNSP.

—HNSP Goal 1: Prevent New HIV Infections—

J. Henrikson noted that this was not the first time they had discussed HNSP. The committee's goal around HNSP was to familiarize themselves with the document, especially in light of the upcoming Consumer Survey. She made the following worksheet so they could review the plan together.

She read the Goal 1 strategies listed at the beginning of the worksheet. A lot of this, she said, was related to what they had previously discussed. Even within the letter, it stated that the language used aligned with HNSP and EHE. During past Prevention Committee discussions, they had conversation around people living without and at risk for HIV, but they would also highlight the importance of helping PLWH reach and maintain viral suppression as a means of prevention.

Keeping in mind the context, she directed attention to the bottom two bullet points on the worksheet. D. Gana asked if this was referencing PrEP resources or HIV resources. J. Henrikson said they were to consider both. They were to discuss HIV treatment as prevention, but they did not want to forget about PrEP. A. Williams said that they read a bulk of the strategic plan. One part of the plan that stood out to them was that only 1/3 of the population nationwide had been tested. This got them thinking about expanding access to testing resources. From a treatment as prevention standpoint, they personally felt that there was profound ignorance around HIV care that highlighted treatment as prevention. They considered the need for an entire shift in marketing around HIV prevention. They added, regarding COVID-19, COVID-19 had taken up a lot of conversational space, and the committee/future discussions needed to consider how to take the conversation back.

D. Gana said that the COVID-19 response from the general public was somewhat similar to the HIV response. People who did not want to get tested simply did not get tested. C. Steib asked if D. Gana was referring to peer-pressure or stigma. D. Gana was referring to the opt-out policy for HIV testing, an issue they had battled with for years regarding HIV. C. Steib said this was a good point, but he was unsure as to how they could tackle that issue. He continued, noting that he was discussing PrEP knowledge for youth recently. He noted that there was a lot of information around PrEP around, but so many people still did not know or understand what PrEP was.

K. King-Collins asked C. Steib had come to this conclusion—she agreed that people did not understand what PrEP or PEP was, but awareness had greatly increased. For the youth that she talked to, they had seen advertisements and could recognize PrEP. She felt that marketing was somewhat working. She agreed, however, that knowledge around the details were much more uncommon. A. Williams said that the population that they served did not seem to know about PrEP. They personally felt that those who were part of a sexual or gender minority might have increased awareness to PrEP. Those in municipal health centers might experience different levels of awareness. K. King-Collins agreed with this. A part of this, she said, was that marketing mostly target toward LGBTQ individuals, so it was likely that many felt PrEP was specific to the queer community. She was unsure if the advertisements for PrEP were only marketed towards certain populations. A. Williams said, based on trends in Philadelphia, this would make sense. However, there were also disproportionate infections for heterosexual women of color.

When looking at the strategic plan, A. Williams said that nationwide there was only around 18% of people indicated for PrEP. However, in Philadelphia, this percentage was around 32.9% (2018 data). Then in 2019, this went up to 37.8%. However, in January-June of 2020, this went down to 28.1%. As an explanation, it was thought that people were social distancing and not needing PrEP anymore. However, it was possible that people were not engaging with their medical providers and still participating in risk behaviors associated with HIV. C. Steib agreed with A. Williams. C. Steib said his organization served a lot of young heterosexual women who had experienced sexual assault. He felt most of the marketing was geared toward the LGBTQ+ community. He suggested that advertisements, especially targeted ones on social media, were presented mostly to LGBTQ+ individuals and that heterosexual women might be closed off to such marketing.

M. Ross-Russell said that within NHBS (National HIV Behavioral Surveillance), there were questions specific to PrEP that would gauge knowledge amognst different populations such as PWID, heterosexual women, youth, transgender women, etc. Her memory was that there were differences in knowledge of PrEP and various other services depending on demographics. This might help them think through their next steps.

G. Grannan said there were risk behaviors that continued throughout the pandemic. M. Ross-Russell said that internally, OHP has talked a lot about COVID-19 as well, but this had a tendency to monopolize conversations. All of the other issues had gone away. She added that knowledge needed to be repeated generationally, and just because knowledge was disseminated among older generations did not necessarily mean it was being passed down to younger generations.

V. Whitt suggested that youth dismissed information that did not seem directly relatable to them. Youth were also very peer oriented so they would get their information from friends. She explained that C. Steib had told her about how one organization posted information about PrEP and PEP on a dating site app where youth would see it. She felt this was a strong example of how information could find youth versus youth finding the information.

D. Gana mentioned multiple lawsuits against pharmaceutical companies, noting that this turn people off of PrEP. Additionally, there was a clinical trial of 6-month injectable PrEP at the University of Pennsylvania, but it was geared toward MSM (men who have sex with men). K. King-Collins asked if there was discussion around PrEP in safe injection sites or intravenous substance use places. A. Williams said that on page 14 of HNSP, there was discussion around the opioid epidemic and syringe use and the barriers, but it did not get too much into how this affected rolling out PrEP resources. G. Grannan responded, saying that based on his experience, knowledge was being disseminated among PWID largely due to Prevention Point's work. He noted that since PrEP was introduced, there had been research to affirm its effectiveness for PWID. This knowledge was starting to become more common. However, he felt that PWID would not think about PrEP first in their assessment of risk. Hepatitis C and overdosing was a much higher priority when considering risk for PWID. G. Grannan said that when people first started injecting substances, they were at higher risk of acquiring HIV—this was likely due to their lack of resources and community knowledge. The longer people were engaged, the better their knowledge of safety. Ultimately, people made their own risk assessments, and organizations could only offer tools.

A. Williams said the conversation around substance use was always in terms of opioid use, but in the HNBS, there was a journal article that said that 1 in 3 annual HIV seroconversions among sexual and gender minorities were consistent methamphetamine users. They suggested that the committee not skip over this fact. G. Grannan responded that, while people were consuming opioids, they were actually talking about polydrug use which included the consideration of methamphetamines. It was rare that an individual only used methamphetamines. However, they should look into this since methamphetamine use increased in every community.

C. Steib said, as someone who worked at a hospital, normalizing regular HIV testing presented barriers beyond his scope. His original goal was to routinize HIV testing. The policy was now in

place at his organization, but there were barriers with EMR prompts, etc. He explained that institutional policies were now asking them to take a step back on their successes. There were institutional barriers against HIV testing, even if providers advocated for HIV testing.

J. Henrikson said this conversation was a way to start talking about how they could incorporate HNSP in their thinking going forward and acknowledge barriers as they thought about ways to increase testing. J. Williams said there was importance in being focused. If they reduced transmission rates for MSM and trans women, they would not have an epidemic in Philadelphia. There was a lot of focus on queer individuals, yes, but that was because the HIV epidemic was concentrated in these areas and these individuals needed the prevention tools. They needed to focus on Black women as well. It was not about who was more deserving of HIV prevention—everyone deserved the tools—but it was important to follow the data and do better by the populations disproportionately affected.

A. Williams agreed with J. Williams about the populations that needed the resources most—however, the specific risk behaviors that those populations were engaged in also played into the proliferation of the infections. For example, in that light, chemsex (using substances alongside sexual activities) was not given its due discourse.

K. King-Collins said the committee needed to think about the intersectionality and their successes or failings with reaching certain populations. She said it was important to look into why there were increases in HIV diagnosis for Black, heterosexual women. J. Williams said research around the "bisexual bridge" did not exist, but there were more consolidated viral loads within certain communities. They needed, then, to look at the systemic factors and how they, as a committee, could address individual aspects. The committee also needed to consider how they could reframe what they were saying to be less from a "public health perspective" and more a "client perspective" that honored clients' needs and wants.

G. Grannan said that, when discussing safety practices with PWID, there was not always direct discussion around HIV prevention. He agreed with J. Williams, saying they needed to focus on what the person wanted and seeing from their perspective. The discussion around use of clean syringes was used not to prevent HIV, per se—clean syringes were used because it was less stressful or painful, among other reasons. K. King-Collins said that they had to reframe their messaging to speak to people's needs. G. Grannan said specific populations sometimes had issue with speaking positively about pleasure. So, broadly, they should destigmatize and center the goals of people at risk.

J. Henrikson said the committee's conversation thus far was very valuable. The original plan was to take the conversation they had, and at the next meeting, see if there was anything actionable. They did not need to come up with anything concrete right now.

J. Williams said that he saw how over the months, when HIPC had a project, they did well. AACO's strategic prevention plan, he felt, pulled from the guidance of HIPC discussions. He said that Prevention Committee could help draft the strategic prevention plan if they would like. Ideally, he would bring the plan back to HIPC anyways. He suggested that this be a monthly agenda item if the committee was interested.

M. Ross-Russell noted that the next big project for Prevention Committee, in addition to the Consumer Survey, was thinking about the Integrated Plan and the guidance that was already out. The Situational Analysis for the Integrated Plan would likely be an expansion of the existing EHE Situational Analysis. The goals for the Integrated Plan, EHE, and HNSP supported the same activities, goals, and objectives. Her read of the Integrated Plan, she felt, was looking at HNSP and EHE goals and incorporating them into the process. She said AACO's strategic plan was likely "step 1" in what would be the work of the next several months.

J. Williams said, then, he could partner with staff to pull together an outline to look into the strategic plan. Prevention Committee could look into what prevention activities were occurring and any activities that were underperformed. A. Williams liked this idea. J. Henrikson said this would help to give structure to the discussion around EHE and HNSP. L. Matus agreed. L. Matus said the AACO partners would be offering data that was currently being collected, so this would help as they tracked results and progress.

Other Business:
None.

Announcements:
J. Williams announced that there would be a flyer going around for a community and client EHE town hall. There would also be an EHE-related event for Philadelphia in October.

Adjournment: C. Steib asked for a motion to adjourn. **Motion**: D. Gana motioned, G. Grannan seconded to adjourn the June 30, 2021 Prevention Committee meeting. **Motion passed**: All in favor. Meeting adjourned at 4:04 p.m.

Respectfully submitted:

Sofia M. Moletteri, staff

Handouts distributed:

- June 2021 Prevention Meeting Agenda
- May 2021 Prevention Meeting Minutes
- Recommendation Language Approved May 2021
- NHBS Goal 1: Prevent New HIV Infections Worksheet