



ADDRESSING SOCIAL DETERMINANTS OF HEALTH IN HIV PREVENTION, TREATMENT, AND CARE:



Lessons Learned from Real World Implementation



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Introduction and overview of guide:¹

Working Definition

The Capacity Building Assistance Provider Network (CPN) defines *Social Determinants of Health (SDH)* as “the complex, integrated, and overlapping social structures, policies, and economic systems, including the social and physical environments, health services structure, and societal factors that are responsible for most health inequities” (CPN Glossary, 2015).

Examples of social determinants would include (but are not limited to) race, gender, sexuality, ability, citizenship/immigration status, education, income and wealth, housing, transportation, health systems and services, social safety network, food insecurity, unemployment/employment and working conditions, public safety, and social exclusion/inclusion (Bryant et al., 2011).



SDH and the National HIV/AIDS Strategy (NHAS) for the United States: Updated to 2020

According to the NHAS for the United States: Updated to 2020:

“The Nation cannot meet the Strategy goals without reducing disparities. Poor social and environmental conditions, coupled with high rates of HIV among specific populations and in specific geographic areas, contribute to stubbornly persistent—and in some cases, growing—HIV-related health disparities” (NHAS, 2015).

Purpose of Guide

This “SDH Guide” is intended as a working document to support health equity work and highlight existing efforts toward addressing SDH. Supplemental materials, such as presentations and downloadable webinars are available to support understanding and ~~use~~ **efusing** this document and the case studies. These webinar slides and other training materials will guide capacity building assistance (CBA) providers and others in ways to present the case studies and use this document to support their ongoing work around addressing SDH.

Published examples of SDH interventions in the HIV prevention and care field that have outcomes beyond individual health, such as at the community, policy, or organizational level are rare. The guide outlines specific case studies with associated outcomes (at the policy, community, or organizational level, for example) that can be used when discussing the impact of SDH interventions, along with two strategies that support integrating SDH into organizational policy. *It should be noted that while there are examples of lobbying efforts and advocacy done in partnership with CBA providers, no federal funds were used to support advocacy and lobbying. Nor are we suggesting that CBA providers engage in lobbying or*

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advocacy. The focus of CBA work in these areas should always be on education and training only.

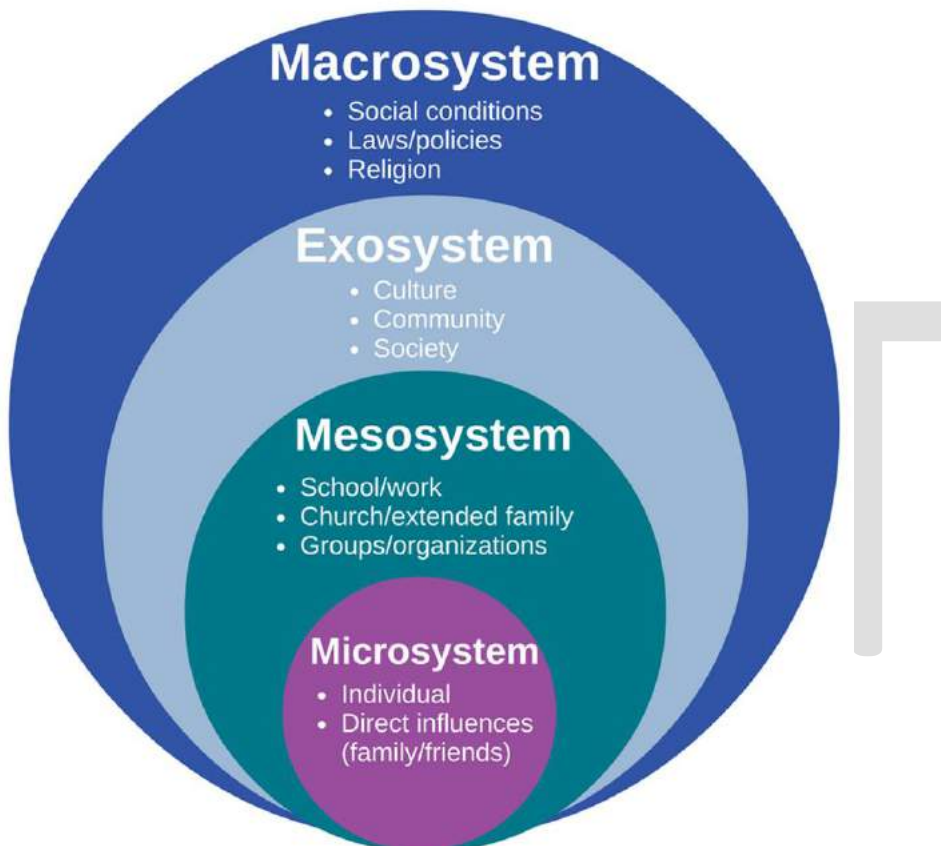
Many of these case studies are based on in-depth interviews with those participating in the work in the field rather than a meta-analysis of available published research. Each case study provides the source(s) for the case study along with further references. Careful consideration was given to ensure that examples were inclusive of health departments, community-based organizations, and healthcare organizations and diverse geographically, by target population, and by specific determinant. This is not an exhaustive collection of the literature and case studies, but rather an initial review to highlight some key lessons learned in regard to the implementation of SDH in HIV prevention, treatment, and care. This working document will continue to add case studies related to diverse underserved populations and specific to different determinants as these case study examples are cleared by CDC.

Ecological Systems Theory and Health

Ecological Systems Theory provides a strong framework to understand the complex intersection of factors that may impact our health (Bronfenbrenner, 1979). Instead of focusing on changing individual behavior through interventions and viewing health challenges as pathological, systems theory focuses our attention on the dynamic interaction between the different layers of influence in our environment. This is often depicted with concentric circles, which emphasize the interconnection of these layers (called *systems*) of influence (from the *microsystem* of the individual and those that directly influence us; to the interacting *mesosystem* of family, groups, and the impact of institutions such as school and church; to the links to the *exosystem* of community, society, and culture; to the context of the *macrosystem* of global influence) and the impact of these interacting systems on individual health and behavior. By raising awareness of the complex intersection of systems that may either hinder or facilitate our success (in life as well as in health), Ecological Systems Theory challenges the assumption that we as individuals can simply change our behavior.

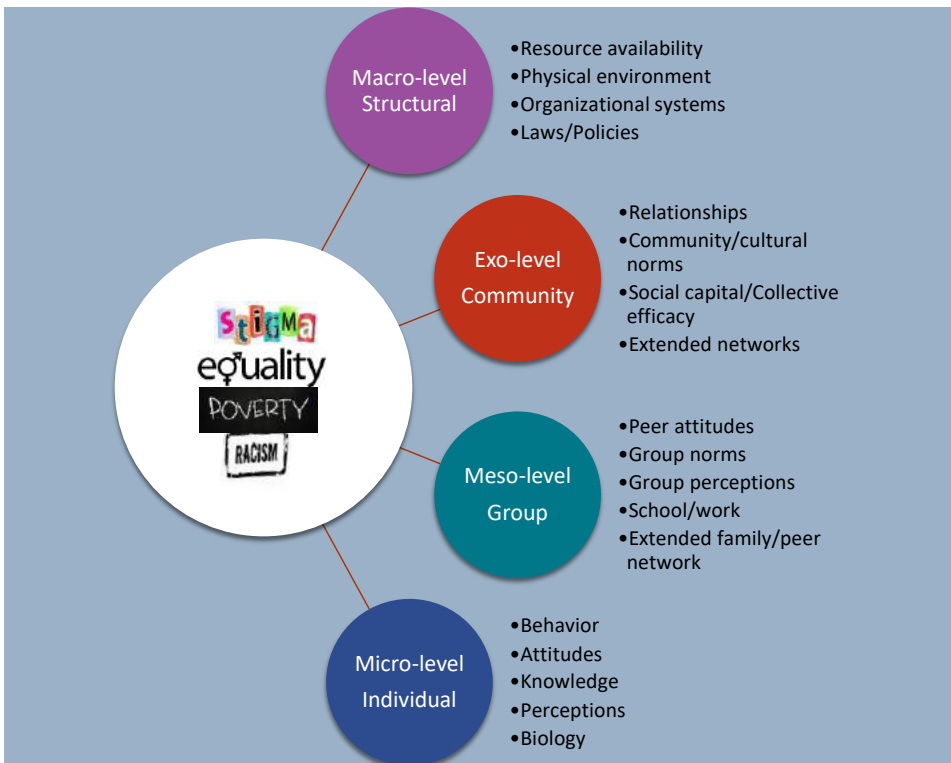
For example, if we look at our own systems of influence very broadly, we may see some of the following influences (Figure 1) and how these are interconnected:

Figure 1: Global example of the levels of influence in Ecological Systems Theory.



Looking at SDH within the context of systems theory allows us to explore how social determinants may impact our behavior individually. It also emphasizes that there are systems of oppression and privilege that interact to impact structural factors such as access to healthcare, what are identified as health norms within a community, and perceptions of healthcare efficacy. This ecological model enables us to engage in interdisciplinary dialogue around a variety of health issues. It further causes us to identify new points of intervention beyond individual behavior to look at systems change and to acknowledge that changes at any level of the system can impact other parts or even the whole system (Bronfenbrenner, 1979).

Figure 2: How SDH may affect HIV prevention and care.



SDH and HIV Prevention

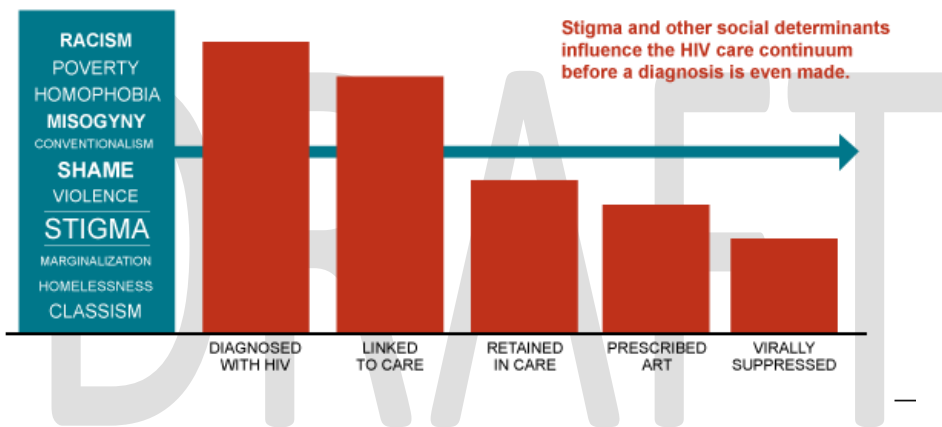
We cannot address HIV prevention without increasing our awareness of the intersection of SDH and the need for interventions at multiple levels of the system. As Figure 2 shows, intersecting SDH factors such as gender inequality, structural racism², stigma, poverty, and

² Structural racism refers to the “Totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice” (Bailey et al. Structural racism and health inequities in the USA: evidence and interventions. *Lancet*. 2017;389:1453-1463).

(footnote continued)

citizenship status can impact HIV prevention and ~~care~~ care and service delivery by limiting resource availability, reducing access to testing and care; correspondingly, the collective efficacy in addressing HIV prevention is diminished. To address the social determinants of health in relation to HIV, we must focus our attention on meso- to macro-level interventions, rather than individual behavior (at the micro-level). Funding streams predominantly focus on individual behavioral change. However, to fully address HIV prevention in our society, we need to look beyond individual change to the systemic barriers that impact the HIV care continuum. Social determinants of health have implications across the HIV care continuum and influence the HIV care continuum before a diagnosis can even be made (Figure 3).

Figure 3: The implications of stigma and other social determinants for the HIV care continuum (Source: [NASTAD, 2014](#)).



Why Case Studies?

Addressing issues related to SDH and HIV prevention, such as structural racism, can often feel overwhelming [when developing capacity building assistance \(CBA\) service delivery components](#) due to the complexity and interdependence of these issues. By reviewing approaches that have demonstrated outcomes beyond individual behavioral change, we can share insights into the diversity of approaches that support high-impact HIV prevention (HIP) work and show how the HIV prevention and care field can collaborate to effect change at myriad levels of the system. This may involve collaborations outside the prevention and care field to develop interventions that address SDH such as housing, and/or to engage civically. As previously noted, this guide is a living document and new case studies will be included annually (as cleared by CDC) to help outline lessons learned when implementing SDH in HIV prevention, treatment, and care.

Selection Criteria

The examples included in this guide are sourced from conference presentations, published articles, and in-depth interviews. Initially, search criteria focused on only peer reviewed published articles did not provide sufficient examples with outcomes beyond individual, such as organization, community, and/or policy. By scouring myriad sources, such as peer reviewed journal articles, available conference proceedings, evaluations from ongoing grants, and reaching out to experts in the field, we compiled a list of interventions which offered outcomes and allowed us to distill some lessons learned from initiatives. The following criteria were used in selecting which interventions were used for the “lessons learned” case studies:

- 1) The intervention focused on one or more social determinants of health.
- 2) The intervention clearly describes how the determinant(s) impact(s) HIV incidence or prevalence.
- 3) Published/documented outcome data are available. This outcome data demonstrate change beyond individual/micro-level behavioral determinants.
- 4) The intervention identifies key stakeholders involved.
- 5) The collective interventions are inclusive of all CBA provider categories; examples are diverse geographically, by target population, and by specific determinant.

Framework

Each case study clarifies the issue/challenge, describes the project, the collaborators, the source for the case study, the level of intervention, outlines the results, and concludes with brief lessons learned developed in collaboration with those engaged in implementing these interventions. A final summary collates the lessons learned and offers some potential strategies to integrate SDH into practice and policy.

List of Case Studies

We selected the current case studies based on population and geographic diversity, clarity of outcome, available information, and relevance to our current HIP work and priority populations. The initial set of case studies includes:

- 1) Iowa Becomes First State to Reform HIV Criminalization Law.
- 2) Decreasing Institutionalized Racism and Trans/Homophobia in Louisiana.
- 3) Addressing Barriers to the Integration of Routine HIV Screening within Clinical Settings: Beliefs, Behaviors, and Cultural Change.

- 4) PILLAR Program Takes on Stigma and Homophobia in Laredo, Texas, with Huge Results!
- 5) Increasing Cultural Responsiveness Among HIV Providers in North Carolina.
- 6) Connect-to-Protect (C2P) Program Uses Community Mobilization Approach to Increase Access to HIV Treatment.
- 7) The Radical Inclusion of Sexuality, Gender, and HIV in the Black Church: A Framework for Addressing Stigma.
- 8) After a 17-year Ban, New York State Approves Medicaid for Transgender-related Healthcare Services.
- 9) A Holistic Approach to HIV Prevention and Treatment.

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NASTAD (2014). Addressing Stigma: A Blueprint for Improving HIV/STD Prevention and Care Outcomes for Black & Latino Gay Men. Available from: <https://www.nastad.org/sites/default/files/NASTAD-NCSD-Report-Addressing-Stigma-May-2014.pdf>. Accessed August 1, 2015.

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Case Study 1.

Iowa Becomes First State to Repeal and Reform HIV Criminalization Law



** It is important to note that while this case study references lobbying efforts in partnership with advocacy groups, federal funds were not and are not allowed to be used to lobby elected officials. Our CBA efforts must focus on education only.*

Background

Issue³

Since 1998, Iowa had upheld one of the harshest HIV criminalization laws in the United States. Iowa state law 709c made it a felony for persons living with HIV infection (~~PLWH~~PWH) who were aware of their serostatus to “expose the body of one person to a bodily fluid of another person in a manner that could result in the transmission” of HIV (Iowa Code Section 709C). If convicted, this felony, punishable by up to 25 years in prison, was an automatic flat sentence. Under the former law, PWH could be found guilty of the stated felony even if they used a condom during sex with no resulting transmission of HIV. Furthermore, the accused would be forced to register as a sex offender. If a person was unaware of their HIV positive status, he or she could not be held liable under the law, so public health attempts to encourage HIV screening were severely and negatively impacted.

Issue⁴

~~Under the former law, PLWH could be found guilty of the stated felony even if they used a condom during sex with no resulting transmission of HIV. Furthermore, the accused would be forced to register as a sex offender.~~ This law created unfair treatment of PLWH, increased stigma for persons seeking care and treatment, and created further barriers to HIV testing. ~~If a person was unaware of their HIV positive status, he or she could not be held liable under the law, so public health attempts to encourage HIV screening were severely and negatively impacted.~~

Target Population:
People living with HIV

Geographic Location:
Des Moines,
Iowa, USA

Social Determinant:
Policy/Law

Time Frame:
2009 – 2014

Sources:
Interview and peer-reviewed articles.

³ Author and contact for this case study is Patrick Piper, California Prevention and Treatment Center (CAPTC). Email: [Patrick Piper](mailto:Patrick.Piper@ucsf.edu) at: patrick.piper@ucsf.edu.

⁴ Author and contact for this case study is Patrick Piper, California Prevention and Treatment Center (CAPTC). Email: [Patrick Piper](mailto:Patrick.Piper@ucsf.edu) at: patrick.piper@ucsf.edu.

Project

The Community HIV/Hepatitis Advocates of Iowa Network (CHAIN), an advocacy group, identified the HIV criminalization law as an issue. CHAIN decided that it was time to modernize the state's HIV laws based upon up-to-date science.

Process

A group of advocates began to garner support from PLWHPWH, concerned community members, the public health department, and eventually members of the state legislature. They conducted outreach and social-marketing campaigns to raise awareness of the issue. Partners included other advocacy groups such as Positive Iowans Taking Charge (PITCH) and the Sero-Project, both groups fighting for the rights of PLWHPWH. In addition, they joined with One Iowa, a marriage equality group. Other groups involved with this effort were The Family Planning Council of Iowa, The Interfaith Network, The Public Health Department, and Iowa ACLU. After two years, they gained support from Lambda Legal Center for HIV Law and Policy, which helped get the attention of the state Attorney General's office. ~~They found an ally in then-Iowa Senator Matt McCoy, who helped draft and submit the bill to, and put it before the state legislature and ultimately to Governor Terry Branstad for signature.~~ On May 30, 2014, ~~the Governor Branstad signed the bill into law, thus shifting. The new law shifted to focus punishment to on~~ people who intend to transmit the disease without another person's knowledge or consent. In addition, ~~rather than single out HIV, the law now includes other infectious diseases such as tuberculosis, meningitis, and hepatitis while making criminal sentencing a tiered system.~~

Results

Advocates in Iowa ~~had~~ fought for several years to ease the law, which now will allow for a tiered-sentencing system—a range of felonies and misdemeanors, depending on exposure and transmission of the disease—rather than a flat 25-year prison term. Those convicted under the law will no longer have to register as sex offenders, and those who had been forced to do so in the past will have their record expunged. Sean Strub, executive director of the Sero Project, a network of people with HIV fighting to change the criminal transmission laws, said of the Iowa legislation, “It just shows how effective it is when people with HIV work in partnership with public health professionals and other advocates...We've improved public health. We've brought greater justice to people with HIV and taken an important step toward reducing stigma.” (NBC News, May 2014)

Lessons Learned

The key lessons learned are:

- *Assign at least one person to lead the efforts.*
- *Seek support from ~~many different~~ diverse sectors of the community, not only those immediately involved, and gain buy-in from these stakeholders.*
- *Build and foster relationships between the community and formal structures such as public health and government.*
- *Be visually present and demonstrate consistency.*

Sources

Portions of this information were gathered from an in-depth interview with Pat Young, HIV and Hepatitis Prevention Program Manager, Iowa Department of Public Health, conducted by Patrick Piper, CAPTC, January 2016.

Galletly, C., Lazzarini, Z., Sanders, C., & Pinkerton, S. D. (2014). Criminal HIV Exposure Laws: Moving Forward. *AIDS and Behavior*, 18(6), 1011–1013.
<http://doi.org/10.1007/s10461-014-0731-1>

[NBC News \(March 29, 2014\)](https://www.nbcnews.com/news/us-news/sex-offenders-no-more-iowa-reconsiders-tough-law-hiv-exposure-n53081). Sex Offenders No More? Iowa Reconsiders Tough Law on HIV Exposure. Available from: <https://www.nbcnews.com/news/us-news/sex-offenders-no-more-iowa-reconsiders-tough-law-hiv-exposure-n53081>

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Case Study 2. Decreasing Institutionalized Racism and Trans/Homophobia in Louisiana



Issue Background⁵

Structural factors such as low socioeconomic status (an estimated 45% of African Americans in Louisiana live in poverty) and limited insurance coverage (42% of African Americans in Louisiana under the age of 65 are uninsured), combined with the effects of structural racism and homo/transphobia, contribute to disparities in health outcomes among racial and ethnic minorities in Louisiana. These social determinants create significant barriers to access to HIV prevention, treatment, and care services. In 2012, African Americans accounted for only 32% of Louisiana's population, but 68% of people living with HIV (PLWHPWH) and 73% of all deaths among PLWHPWH. The majority of HIV diagnoses (53%) were among men who have sex with men (MSM), with African American MSM representing 66% of the overall MSM diagnoses.

Target Population:
HIV service providers

Geographic Location:
New Orleans, Louisiana,
USA

Social Determinant (s):
Racism; Trans/Homophobia

Time Frame:
2013 – 2015

Sources:
Published articles and
presentations.

Issue

The majority of HIV and STD cases in Louisiana are concentrated in three cities: New Orleans, Baton Rouge, and Shreveport. Together, these three metropolitan areas accounted for 66% of new HIV cases reported statewide in 2012.

Project

The Louisiana Department of Health and Hospitals, Office of Public Health, STD/HIV Program (SHP) has developed six complementary strategies for their Care and Prevention in the United States (CAPUS) Demonstration Project, entitled "Addressing Louisiana Inequities in HIV and AIDS" (ALIHA): (1) Laboratory Information Management System Strategy (LA LIMS); (2) Louisiana Links Strategy (LA Links); (3) Louisiana Testing Strategy (LA Testing); (4) Louisiana Health Models Strategy (Health Models); (5) Social Marketing Strategy (Social Marketing); and (6) Louisiana Capacity Building Assistance Strategy (LA CBA). Collectively, these interventions are designed to address the social determinants of health that affect HIV disparities among racial and ethnic minorities, particularly African Americans and men who have sex with men (MSM), in the highest-prevalence areas of the state, namely New Orleans, Baton Rouge, and Shreveport.

⁵ Author and contact for this case study is Patrick Piper, California Prevention and Treatment Center (CAPTC). Email: [Patrick Piper](mailto:Patrick.Piper@ucsf.edu) at: patrick.piper@ucsf.edu.

Process

As part of the capacity-building component of this initiative, health department staff and staff of three other agencies (CrescentCare, Priority Health Care, and HAART) completed workshops about institutional and structural racism, heterosexism, and transphobia. These workshops seeded an initial shared understanding of the history of these oppressions, as well as shared language and analysis among the staff of each organization on how to address racism, heterosexism, and transphobia. During this reporting period, SHP provided capacity building for all four agencies to begin building internal alignment around the importance of addressing racism, heterosexism, and transphobia to successfully achieve their missions. This led to a commitment to integrate HIV equity work in the next 1–2 years, thus laying the foundation for each organization to continue to deepen their work to address structural inequities. Each of the four participating agencies formed design teams of five or more individual leaders representing a cross section of departments, roles, perspectives, and demographics. Each design team led an inclusive and collaborative process within their agency over a period of six months. The objectives of each design team were to help their organization to:

- 1) Deepen their understanding of the barriers that Black, Latino, MSM, and trans-men and trans-women face related to HIV (both inside and outside healthcare settings).
- 2) Clarify how their agency is uniquely positioned to reduce those inequities.
- 3) Agree on action steps the organization will take to implement a plan for creating HIV equity in the next 1–2 years.

In 2014, six *Deconstructing Homophobia and Transphobia* workshops were held as part of the *Louisiana Capacity Building Assistance Strategy* (LA CBA Strategy), a component of the *Care and Prevention in the United States Demonstration Project* (CAPUS). In year 3, the program worked with Interaction Institute for Social Change to take a deeper dive into the intersectionality of all three oppressions: institutional racism, homophobia, and transphobia and see how to make structural changes that move toward health equity in Louisiana.

Results

Initial findings from a six-month post-training evaluation survey of participants who attended the six “Deconstructing” workshops found that staff members described the *Deconstructing Homophobia and Transphobia* workshop as useful and stated they talked with others about it. Approximately one-third of respondents reported altering the way they work with clients or colleagues since the workshop, due to increased awareness of intolerance generally and transgender issues specifically. Staff have become more inclusive in their communication, and some believe they provide better services, especially to transgender clients. However, respondents offer mixed responses to the question of whether their organizations have altered practices or procedures over the six-month period following the workshop. Those who have observed change report ongoing discussions about information from the workshop, as well as the creation or alteration of policies and procedures. When asked whether they have observed changes in the way their

organizations reach out to or provide access to clients, respondents are almost equally divided between those who say “Yes,” those who say “No,” and those who are unaware of any changes. The majority of staff members who participated in the six-month survey report that the workshop is useful, although some have suggestions for ways it could be improved.

Lessons Learned

The key lessons learned are:

- *Meaningful conversations about racism, homophobia, and transphobia take a long time and require an examination of unearned privilege.*
- *Organizational change is slow.*
- *Leadership involvement and staff buy-in are critical to the success of this work.*
- *Following up with teams and individual staff after these workshops is essential. It is heavy content, and participants need time to process and digest.*
- *Do not rush to solutions. This is what many well-meaning white people want to do instead of examining their own privilege. Cultural humility = recognizing privilege.*
- *Prevention efforts solely focusing on individual behavior change will not end the epidemic; they must be coupled with an understanding of the structural racism, transphobia, and heterosexism impacting clients' lives.*

Sources

Deconstructing Homophobia and Transphobia Workshop: Analysis of Qualitative Responses in 6-Month Follow-Up Questionnaire; Project Year Three; Louisiana Office of Public Health, STD/HIV Program Care and Prevention in the United States Demonstration Project: Addressing Louisiana Inequities in HIV and AIDS; May 2015

Fitch, J. (2015). “Addressing Racism, Homophobia, and Transphobia: One Health Department’s Approach.” Louisiana Department of Health.

Gruber, D. (2013). CAPUS Executive Summary: Louisiana Department of Health and Hospitals. Available from:
https://www.cdc.gov/hiv/pdf/research/demonstration/capus/granteelouisiana_web508c.pdf

Case Study 3.

Addressing Barriers to the Integration of Routine HIV Screening within Clinical Settings: Beliefs, Behaviors, and Cultural Change



Background⁶

The Care and Prevention in the United States (CAPUS) demonstration project is focused on reducing HIV/AIDS-related morbidity and mortality among racial and ethnic minorities in the United States

~~Through CAPUS, the implementation of the Care and Prevention in the United States (CAPUS) demonstration project, the Public Health Institute of Metropolitan Chicago (PHIMC) developed several strategies to address a number of organizational and systemic barriers to routine HIV testing within clinical systems. These included perceived burden of time, competing priorities, lack of knowledge and training, misconception regarding consent and counseling requirements, perceived lack of patient acceptance, and inadequate reimbursement process. While working with sites, PHIMC also identified the need to address the personal bias of healthcare providers, which can impact the delivery of healthcare services. To that end, PHIMC initiated the Protecting our Patients (POP) campaign, which is designed to address HIV stigma among clinical providers in order to address HIV/AIDS in general.~~

Issue

While working with sites, PHIMC also identified the need to address the personal bias of healthcare providers, which can impact the delivery of healthcare services. To that end, PHIMC initiated the Protecting our Patients (POP) campaign, which is designed to address HIV stigma among clinical providers in order to address HIV/AIDS in general.

Project

PHIMC initiated the Protecting our Patients (POP) campaign, which is designed to address HIV-stigma among clinical providers in order to address HIV in general. POP was created to reduce barriers to routine testing by challenging individual and institutional stigma. The CAPUS demonstration project is focused on reducing HIV/AIDS-related morbidity and mortality among racial and ethnic minorities in the United States. Through CAPUS, PHIMC led an initiative to implement routine opt-out HIV testing in a variety of healthcare settings

Target Population:
HIV service providers

Geographic Location:
Illinois, USA

Social Determinant:
Stigma

Time Frame:
January 2014 – June 2015

Sources:
This information was gathered from a conference presentation and an interview with Jamie Gates, Public Health Institute of Metropolitan Chicago.

Commented [A1]: This case study seems to be addressing two issues: stigma related to testing and the POP project. It may be helpful to separate the two issues, since both are key determinants to individuals choosing an HIV test. An alternative may be to focus only on the POP project, since service providers are listed as the target population.

⁶ Author and contact for this case study is Patrick Piper, California Prevention and Treatment Center (CAPTC). Email: [Patrick Piper](mailto:Patrick.Piper@ucsf.edu) at: patrick.piper@ucsf.edu.

in Illinois. Through their participation in the project, agencies developed, expanded, or improved their capacity to integrate routine HIV testing into their practice. Unfortunately, stigma and discrimination toward those perceived to be at risk or living with HIV/AIDS still exists in many healthcare settings.

Through CAPUS, PHIMC led an initiative to expand routine HIV testing in six clinical systems and four county jails. The project supported the successful achievement of the CAPUS goals, most notably by increasing the number of racial and ethnic minorities who know their HIV status, by expanding and improving the capacity of these systems to conduct HIV testing, and by supporting linkage to and retention in care for those newly or previously diagnosed with HIV. ~~POP was created to reduce barriers to routine testing by challenging individual and institutional stigma.~~

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Results

PHIMC conducted a series of focus groups and key informational interviews to better understand the current barriers related to stigma within CAPUS sites. The results from this process showed that providers:

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- 1) Are receptive, but apathetic, to routine screening.
- 2) Are apathetic, but open, to LGBTQ competence.
- 3) Feel unprepared to address the concerns of the LGBTQ population, which increased their discomfort and avoidance of the issues.
- 4) Have concerns for uninformed patient populations.
- 5) Desire testimonies, scripting, role-playing, and information tools to enhance their skills.

Overall, the need for ongoing training on methods, strategies, and cultural considerations when working with LGBTQ populations was emphasized.

Lessons Learned

The key lessons learned are that dissemination strategies for an effective campaign geared toward providers must:

- *Emphasize universal risk and integration.*
- *Compel providers to care about LGBTQ competency.*
- *Update providers on HIV/AIDS.*
- *Be adaptable to various settings and time lengths.*
- *Be administered by a variety of individuals.*
- *Use an internal champion mobilization strategy.*
- *Be online in a way that optimizes the likelihood of providers finding it when searching for resources.*

Sources

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Case Study 4. PILLAR Program Takes on Stigma and Homophobia in Laredo, Texas, with Huge Results!



Issue⁷

In 2009, the Texas Department of State Health Services reached out to the City of Laredo Health Department (LHD) to explore intervention possibilities with some of the local populations at increased risk for STD/HIV. Based on epidemiological data, the Laredo Health Department decided to focus on young, Latino MSM (YLMSM).

A general lack of resources for YLMSM resulted in reduced services available to this population. However, it was also noticed that the services that were available were being underutilized or not accessed at all. LHD had a history of working with this population on an individual basis to address risk behavior and were curious to learn more about what was leading to the lack of access and use.

LHD began an interviewing process, conducting key informant interviews with service providers, community officials, and members of the community itself. These members included business owners, gatekeepers, and YLMSM. Their findings showed that several factors (social determinants) were mentioned as being barriers to access. One of these barriers was the perceived lack of support from family members and school officials, as well as social norms around issues of sex and sexuality. and consequently, the services that focused on those issues. In addition, interviews showed larger issues such as mental health, post-traumatic stress, abandonment, and homelessness impacted risk behaviors among these young men.

Other factors identified included HIV stigma, machismo, homophobia, and religious beliefs. These myriad factors led to a community that was unsupportive of prevention messages. These were simply issues that were not talked about in a small, conservative community. Two major factors that emerged were the negative impact of bullying and suicide within the LGBTQ community, especially regarding YLMSM. It became apparent that these factors were leading to low self-esteem, self-loathing and hopelessness and that those were, in turn, leading to increased risk-taking behaviors. LHD began to realize that, until

Target Population:
Latino youth

Geographic Location:
Laredo,
Texas, USA

Social Determinant:
Stigma/Homophobia

Time Frame:
2009 – 2013

Sources:
This information was
gathered from in-depth
interviews.

⁷ Author and contact for this case study is Patrick Piper, California Prevention and Treatment Center (CAPTC). Email: [Patrick Piper](mailto:Patrick.Piper@ucsf.edu) at: patrick.piper@ucsf.edu.

these larger mental health issues were addressed, their STD/HIV prevention efforts would fall short. Yet these mental-health services, particularly serving LGBTQ persons, were non-existent at the time.

Project

LHD decided that they needed to engage in some community-mobilization activities to raise awareness of bullying and suicide in the LGBTQ community. With seed money from the state health department, they began the process. LHD knew that they needed to gain the trust of the YLMSM community to access its “hard to reach” members. In addition to interviews, LHD staff targeted venue outreach and had a visible presence at community events. LHD also sent out a mass mailing about the issues of suicide and bullying to many sectors of the community, including local businesses, school officials, public health officials, clergy, city and county government, including the mayor and county judge. LHD built a coalition and, nine months later, began to create an organization that would address mental health and behavioral health for the LGBTQ community. They named this organization PILLAR (People with Ideas of Love, Liberty, Acceptance and Respect).

Today, PILLAR is a thriving and growing 501(C)(3) organization and is maintained by a staff of more than 100 volunteers and funding from the United Way, Texas Department of Health Services, and ongoing fundraising efforts. In addition to the services they offer, PILLAR conducts workshops throughout the Laredo Public School system and have included issues affecting the transgender community in the topics they address. Through their efforts, they have impacted public policy, and presently the Laredo Public School system is re-writing their mandates to include at least two sessions on comprehensive sexual-health education for each student. The PILLAR program and organization are embraced and supported by the community, as evidenced by being honored by the local baseball team with “PILLAR Night” in recognition for the work they have done.

In early 2015, PILLAR embarked on the development of Groundwork, Laredo’s first LGBTQ Center. They envision a place where the community can learn, be supported, engage, and grow. Most recently, PILLAR applied to become a licensed Substance Treatment Facility.

Results

By moving beyond the individual and a focus on individual behaviors, PILLAR has managed to affect the more macro-level social determinants of health within the Laredo community. Ongoing efforts, supported by the community, have a more far-reaching and sustainable impact on the health and well-being of the community of Laredo, including HIV testing rates and linkage to medical services (Figure 4).

Figure 4: Results from PILLAR from 2008 to 2013.

Building PILLAR: Lessons in Community Mobilization		
ENGAGEMENT/TESTING STATS	2008	2013
TOTAL HIV tests:	1,621	1,200
MSMs tested:	233	415
MSMs tested - youth:	30%	60%
MSMs tested - adults:	70%	40%
Retention in HIV Medical Care among positive MSMs:	81%	97%
Students engaged in sexual health discussions:	0	15,000
Community partners involved:	0	57

Lessons Learned

The key lessons learned are:

- *Be strategic: It is sometimes easier to enter a community and gain their buy-in on an issue that is related to, but not directly the issue at hand (e.g., bullying versus homophobia).*
- *Partner with communities: You must do the groundwork and spend time mobilizing the community to help in the development of the interventions, as well as the delivery. This creates ownership among all parties.*
- *We need to move beyond a focus on the individual and individual behaviors if we are to impact a community of hard-to-reach people, such as YLMSM. By raising awareness in the community and making this a community-level (rather than individual) issue, PILLAR has managed to affect the more macro-level social determinants of health.*
- *Pursue any potential sources of funding for your activities. Sometimes an organization perceived as unlikely to donate ends up being a big supporter!*

Sources

This information was gathered from a summary of an in-depth interview with Amanda Reese, Texas Department of State Health Services; Renee De La Fuente, Texas Department of State Health Services; Manuel G. Sanchez, Jr., City of Laredo Health Department; Arturo Diaz, Co-Founder, PILLAR Program. The interview was conducted by Patrick Piper, CAPTC, January 2016. To discover more about PILLAR, visit: www.pillarstrong.org/.

Case Study 5. Increasing Cultural Responsiveness Among HIV Providers in North Carolina



Issue⁸

In North Carolina, approximately 67% of those living with HIV are Black/African American, with 85% of males being men having sex with men (MSM) and 50% males aged 13-29 (NC DHHS, 2015). The increasing rate of HIV among people of color, especially young Black MSM (YBMSM) is correlated with socio-economic issues, the impact of criminal justice on the community, stigma around HIV/AIDS, lack of access to healthcare, and institutional racism. As part of their Care and Prevention in the U.S. (CAPUS) initiative, the North Carolina Department of Health and Human Services are addressing a number of structural factors directly affecting HIV testing, linkage to, retention in, and re-engagement with HIV care, treatment, and prevention. A key component of this is working with providers on issues of cultural humility to foster culturally competent care in healthcare settings.

Project

The North Carolina State Department of Health and Human Services (NC DHHS) developed several strategies as part of a statewide effort to collectively address the disproportionate impact of HIV/AIDS on racial and ethnic minorities. These included Cultural Competency Trainings, Minority Men's Clinics, Patient Navigation, and Safe Spaces. A statewide evaluation effort is currently identifying some key outcomes related to this collective effort.

A key strategy of this statewide effort was developing NC-specific cultural competency training for providers working with those living with HIV/AIDS; this included clinical staff as well as those in public health settings who might interact with patients in some way, such as reception room and appointment staff, administrators and financial staff, case managers, social workers, and clinicians. The intent was to shift the culture of an organization, raising awareness of bias and prejudice in the workplace. The state implemented a standardized 12-hour, in-person training, branded as "C3" for "Culturally Competent Care." This curriculum received statewide support from medical

Target Population:
HIV service providers
(institutional systems)

Geographic Location:
North Carolina

Social Determinant(s):
Structural barriers to care; Discrimination;
Stigma; Racism;
Trans/Homophobia

Time Frame:
2014 – 2016

Sources:
Interviews and
conference
presentations.

⁸ Author and contact for this case study is Deena Murphy, CPN Resource Center (CRC). Email: [Deena Murphy](mailto:DeenaMurphy@cpnresourcecenter.org) at deena@cpnresourcecenter.org.

schools, AIDS Education and Training Centers, and the Health Department, who provided certification to all attendees. The mission of this training is to “improve the quality, provision, and availability of Culturally Competent Care (C3) for those individuals who seek healthcare in North Carolina” (Taylor et al., 2016). Core components of this curriculum include 1) Understanding the historical precedents of health and social disparities, including how institutional systems continue to perpetuate these disparities; 2) The importance of sensitivity and understanding when working with HIV+ clients, especially sexual minorities; 3) Cultural differences and the various dimensions of diversity; 4) Participants’ exploration of their own cultural biases and blind spots; and 5) The impact of policies, procedures, and practices on health status (Taylor et al., 2016).

As of December 2017, under the CAPUS grant, almost 900 healthcare and social work providers across over 50 (of the 100) counties in NC participated in C3. While the trainers retain the core components of the training, best practices for implementation include adapting to issues of local communities, encouraging participation from all staff at agencies (not just clinical staff), and ensuring examples are relevant to local and global events.

The C3 training series is being sustained beyond the CAPUS grant as part of an ongoing statewide Health Equity initiative administered under the HIV/STD/Hepatitis Unit of the Communicable Diseases Branch of the NC DHHS. NC DHHS requires C3 training for *all* HIV-care and HIV-prevention contracts.

Results

While data collection is still being processed at the state level related to all NC CAPUS initiatives, 91% of participants viewed the training positively. Initial evaluations of the C3 training series suggest that fostering culturally competent care in healthcare settings can

1. Result in the increased ability of providers to understand, communicate with, and effectively interact with people across cultures.
2. Decrease stigma and discrimination in the healthcare setting.
3. Increase linkage and retention in HIV care, thereby increasing viral suppression and decreasing new HIV-infection rates.
4. Create organizational and policy changes as a result of recommendations from staff who participated in the training series.

Lessons Learned

The key lessons learned are

- *Standardized curriculum around cultural humility can outline core components and retain fidelity to that model. However, context matters, and culturally specific examples and local conditions should always be included.*
- *Support from key stakeholders is necessary to implement a statewide effort.*
- *Grants that mobilize states into addressing SDH are needed to enable resources to be devoted to addressing structural barriers to care and demonstrate the impact of these interventions on HIV prevention and care.*

- *Programs that demonstrate effectiveness create data to support new policy at both the organization and state levels (creating further structural changes).*

Sources

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Case Study 6.

Connect-to-Protect (C2P) Program Uses Community Mobilization Approach to Increase Access to HIV Treatment



Background⁹

National statistics estimate that up to 80% of youth (ages 18–25) in the U.S. are unaware of their HIV status, and, of those testing HIV positive, only 29% are adequately engaged in care and treatment. In addition, many young people find themselves in and out of the juvenile detention system. While this may increase opportunities for HIV testing, adherence to HIV treatment for those testing HIV positive can be challenging, especially post-incarceration. The Adolescent Treatment Network (ATN) is a National Institutes of Health clinical research network composed of 14 Adolescent Medicine Trials Units (AMTUs) located in Tampa and Miami, FL; Los Angeles, CA; the District of Columbia; Philadelphia, PA; Chicago, IL; Bronx, NY; New Orleans, LA; Memphis, TN; Houston, TX; Detroit, MI; Baltimore, MD; Boston, MA; and Denver, CO. The ATN is funded to conduct research on youth who are living with or at risk for HIV. Each AMTU initiated a local C2P coalition that was charged with the primary goal of achieving structural change, targeting community-level HIV risk. Since 2006, the C2P coalitions have collectively achieved more than 300 structural changes defined as new or modified programs, policies, or practices that either directly or indirectly influence youth and are sustainable without the C2P coalition's ongoing involvement (Reed et al., 2013; Miller et al., 2016; Ziff et al., 2016). Audits of juvenile detention facilities in Los Angeles County found that many youth were being released from detention without access to HIV medication and linkage to care. This has significant implications on viral suppression and potential HIV transmission among high-risk youth.

Issue

In 2014, an issue brought to a subcommittee in the Los Angeles C2P project was that HIV-infected youth were not receiving their medications upon entry and/or release from the detention center. These youth were

Target Population:
Incarcerated youth

Geographic Location:
Los Angeles,
California, USA

Social Determinant:
Access to HIV treatment

Time Frame:
2013 – 2014

Sources:
Review of four
published articles.

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returning home or to a group home without their medications, which has implications for viral suppression. Audits of juvenile detention facilities in Los Angeles County found that many youth were being released from detention without access to HIV medication and linkage to care. This has significant implications on viral suppression and potential HIV transmission among high-risk youth.

Project

Each AMTU initiated a local C2P coalition that was charged with the primary goal of achieving structural change, targeting community-level HIV risk. Since 2006, the C2P coalitions have collectively achieved more than 300 structural changes defined as new or modified programs, policies, or practices that either directly or indirectly influence youth and are sustainable without the C2P coalition's ongoing involvement (Reed et al, 2013; Miller et al., 2016; Ziff et al., 2016). The Adolescent Treatment Network (ATN) is a National Institutes of Health clinical research network composed of 14 Adolescent Medicine Trial Units (AMTUs) located in Tampa and Miami, FL; Los Angeles, CA; the District of Columbia; Philadelphia, PA; Chicago, IL; Bronx, NY; New Orleans, LA; Memphis, TN; Houston, TX; Detroit, MI; Baltimore, MD; Boston, MA; and Denver, CO. The ATN is funded to conduct research on youth who are living with or at risk for HIV. Each AMTU initiated a local C2P coalition that was charged with the primary goal of achieving structural change, targeting community-level HIV risk. Since 2006, the C2P coalitions have collectively achieved more than 300 structural changes defined as new or modified programs, policies, or practices that either directly or indirectly influence youth and are sustainable without the C2P coalition's ongoing involvement (Reed et al, 2013; Miller et al., 2016; Ziff et al., 2016).

C2P builds on the concept of "AIDS-competent communities" defined as collaborative support to achieve community-wide objectives such as access to HIV testing and treatment services. Multiple themes define AIDS-competent communities: 1) Members' skills and knowledge related to HIV and youth; 2) Enhanced dialogue where members have the opportunities to discuss HIV prevention and treatment; 3) Ownership and responsibility; 4) Confidence in local strengths that builds faith in collective efficacy for addressing HIV-related issues; and 5) Solidarity as an outcome of effective relationships and collective successes. Indicators of AIDS-competent communities include knowledge and skills, dialogue among relevant sectors of the community, local ownership of a problem, confidence in local strengths, solidarity or bonding social capital, and bridging partnerships (Reed et al, 2013; Miller et al., 2016; Ziff et al., 2016).

The C2P model is based on the Community Empowerment Framework that broadly defines "the process of gaining influence over conditions that matter to people who share neighborhoods, workplaces, experiences, or concerns" (Boyer et al., 2016). It emphasizes seven factors for successful coalition development and function, including (1) Defining a clear vision and mission; (2) Strategic planning; (3) Coalition leadership; (4) Providing resources to mobilizers; (5) Documentation of coalition efforts and feedback on progress; (6) Technical assistance; and (7) Making outcomes matter. During this mobilization phase, staff also develop partnerships with individuals who might help carry out C2P's mission and become members. The C2P approach uses the power of community stakeholders to bring about structural changes that would be difficult for any single organization to achieve

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independently. During this mobilization phase, staff also develop partnerships with individuals who might help carry out C2P's mission and become members. Members consist of people representing local government, community service organizations, health departments, medical establishments, and faith-based organizations. These stakeholders form coalitions and divide duties among the coalition members. The coalitions develop structural change objectives (SCOs) to guide their work toward their goals. Often, specific duties are delegated to subcommittees that are tasked with carrying out action steps toward meeting their goals (Reed et al, 2013; Miller et al., 2016; Ziff et al., 2016).

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~~In 2014, an issue brought to a subcommittee in the Los Angeles C2P project was that HIV-infected youth were not receiving their medications upon entry and/or release from the detention center. These youth were returning home or to a group home without their medications, which has implications for viral suppression.~~ The subcommittee worked with the Los Angeles County Probation Department to establish internal guidelines regarding post-incarceration placement of HIV-infected youth ensuring they are linked in to care and receive antiretroviral medications (Reed et al, 2013; Miller et al., 2016; Ziff et al., 2016).

Results

In January 2014, the Los Angeles C2P achieved their SCOs, which ensured that all HIV-infected youth within the system (whether incarcerated or post-incarceration) are connected to a linkage worker and receive their antiretroviral medications. This change, which originally targeted the Barry J. Nixdorf Juvenile Hall, has been instituted at all 22 juvenile-detention facilities in Los Angeles County. Subsequently, as an indirect result of these efforts, the Los Angeles County Probation Department has required that social workers at all facilities complete basic HIV training (HIV101) and LGBTQ-cultural-competency education as part of their initiation and professional education process (Reed et al, 2013; Miller et al., 2016; Ziff et al., 2016).

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Lessons Learned

The key lessons learned are:

- Include the priority population in coalitions that are built.
- Foster project ownership among coalition members.
- Assign ongoing duties to coalition members to help keep them engaged in the process and members of the coalition.

Sources

Boyer, C. B., Walker, B. C., Chutuape, K. S., Roy, J., Fortenberry, J. D., and Adolescent Medicine Trials Network for HIV/AIDS Interventions. (2016). Creating Systems Change to Support Goals for HIV Continuum of Care: The Role of Community Coalitions to Reduce Structural Barriers for Adolescents and Young Adults. *Journal of HIV/AIDS and Social Services*, 15(2), 158–179. <http://doi.org/10.1080/15381501.2015.1074977>

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Case Study 7.

The Radical Inclusion of Sexuality, Gender, and HIV in the Black Church: A Framework for Addressing Stigma



Issue¹⁰

The African-American/black, Hispanic and Latinx communities have been burdened with the distinction of being disproportionately affected by HIV/AIDS in the United States for more than two decades. People of color are also more likely to identify a formal religious or faith-based affiliation with their traditional support network when compared with whites. As such, faith leaders and their institutions have been identified in the National HIV/AIDS Strategy as having a vital role to serve in reducing both HIV-related health disparities and the number of new HIV infections. Faith leaders can promote non-judgmental support for persons living with and at risk for HIV/AIDS, but also by serving as trusted information resources for their congregants and communities (Parks & Sutton, 2011).

Bishop Yvette Flunder, a same-gender loving faith leader, HIV service provider, and activist with 30-plus years' experience in the AIDS epidemic, discussed this at The White House's 2014 World AIDS Day event. Flunder's comments regarding barriers to HIV prevention, testing, and treatment highlighted that, while information may be readily available, inequities exist for prevention with black MSM in the U.S. According to the CDC, "if current diagnosis rates continue, about 1 in 2 African-American gay and bisexual men will be diagnosed with HIV in their lifetime — in comparison to 1 in 4 Hispanic/Latinx gay and bisexual men, 1 in 11 White gay and bisexual men, and 1 in 6 gay and bisexual men overall" (CDC, 2016).

Bishop Flunder asserts that the key barrier for accessing HIV prevention and care in communities of color is stigma. Drawing parallels with the 19th-century cholera epidemic, Flunder referenced a faith leader who used stigma to fault marginalized communities for the spread of cholera, an epidemic which at that time lasted for decades. Flunder emphasizes the need to take action and address the root causes of HIV with the analogy of "Just boil the water. Don't stigmatize people. Don't use religion to condemn. Just boil the water" (Flunder, 2016). Bishop Flunder reminds providers, clinicians, and government that stigma from the community, church members, or the pulpit is a costly, powerful tool of hate. "The realities of homophobia, homo-hatred, and heterosexism are particularly harmful to people living with

Target Population:
Faith-Based Community
HIV Service Providers

Geographic Location:
USA

Social Determinant:
Stigma

Time Frame:
2011 – 2014

Sources:
This information was gathered from published articles, online resources, and in-depth interviews with key stakeholders.

¹⁰ Author and contact for this case study is Jill Williams, New York City Department of Health and Mental Hygiene (NYCDOHMH). Email: [Jill Williams](mailto:Jill.Williams@health.nyc.gov) at: Jwilliams6@health.nyc.gov.

HIV... homophobia still kills.” Critical to moving beyond this is “to learn and teach prevention without stigma.” (Flunder, 2016).

Project

The Fellowship of Affirming Ministries (TFAM), founded in 2000 by Bishop Yvette Flunder, is a multi-denominational group of primarily African-American Christian leaders and laity representing churches and faith-based organizations from the USA, Africa, and Mexico. The Fellowship’s overarching purpose is to support religious teachers and laity in moving toward a theology of radical inclusivity,¹¹ which, by its very nature, requires an equally radical social ministry that serves all in need without prejudice and discrimination. (“Our partners” n.d.). The work of TFAM is a promising best practice¹² for faith leaders as the mission, goals, and formal actions challenge religious doctrines that indirectly or directly support the isolation and mistreatment of people through oppressive, exclusionary practices. This ministry and its purpose provides a framework for addressing stigma as a social determinant.

Pastor Vanessa Brown, Senior Pastor of Rivers of Living Water Ministries and TFAM’s Northeast Region Episcopal Liaison, outlined the work of radical inclusion in her ministry in New York City. Brown emphasized Flunder’s earlier faith-based strategies by stating the importance of fostering sexual literacy, theological literacy, and justice literacy as a precursor to embracing the steps of radical inclusivity. Both Brown and Flunder noted that these three strategies (sexual literacy, theological literacy, and justice literacy) can be helpful in de-stigmatizing the AIDS epidemic, thereby opening up ways to effectively utilize faith-based HIV-prevention interventions.

Faith-based strategies to support HIV prevention (sexual literacy, theological literacy, and justice literacy)

Bishop Flunder’s comments on sexual literacy highlight the importance of competency and the obligation adults and faith leaders have to speak and teach about sex. We know HIV is a sexually transmitted disease, so if we talk about HIV prevention, testing, and/or treatment, we have to have a planned methodology for talking about sex. Adults must become sexually literate and have knowledge of sexuality that spans differences in sexual behavior, sexual orientation, and gender identity. In this way, faith-based communities can help young people gain **sexual literacy** skills to demystify sex and be safe. However, this requires competency and culturally appropriate non-punitive ways to talk about sex with our youth.

Theological literacy provides a way for people to harmonize their bodies and their spirits. This strategy proposes that conflict between body and spirit is unnecessary. Instead, the church should speak an affirming message about a loving God that created both our bodies and our spirits, allowing people to comfortably talk about our bodies in conjunction with the

¹¹ Radical inclusivity is “the intentional inclusion of all persons, especially those who have traditionally lived at the margins of society, such as people suffering from substance abuse, people living with HIV/AIDS, same-gender loving people, the recently incarcerated, and sex-industry workers” (“What Is Radical Inclusivity?” 2017).

¹² While there is limited outcome data, we argue that the creation and sustainability of TFAM provides an outcome that is too important to exclude in any guide addressing SDH in the U.S.

spirit. Bishop Flunder notes we have to acknowledge the reality of homophobia in the church, both internal and external. There continues to be oppression toward people living and dying with AIDS and particularly toward same-sex loving people, transgender people, and people living with HIV. Homophobia is painful and still kills “not just in the violence against same-gender loving people, but in the inequitable and tardy response of religion and society to the AIDS epidemic” (Flunder, 2016).

Justice literacy refers to building the capacity of youth to seek justice. In this pandemic, it means empowering young people to have facilitated conversations to discuss the dysfunctions in our families, in our communities, and in our churches. Bishop Flunder identifies these dysfunctions as “abuse, incest, molestation, rape, and abuse by clergy. We need to break away from the silence that is the precursor to not talking about sex and healthy love of our bodies. We must openly talk about HIV and AIDS.” (Flunder, 2016). According to Pastor Vanessa Brown, using **sexual literacy** in her ministry helps congregants feel comfortable and empowered to promote sexual health and wellness that includes HIV prevention and HIV-medication adherence. In reference to **theological literacy**, Pastor Brown states that many clergy use the bible and scripture to reject and isolate people and that it is our interpretation of the bible that is problematic and divisive. Messaging around body and spirit from scripture should be healthy and not something to fear. Pastor Brown highlights that **justice literacy** is valuable in that we must see HIV not only as a health issue but also as a justice issue — justice for the poor, justice for those who have experienced discrimination, and justice for stigmatized communities and people. Pastor Brown outlines the success of her church as due to the commitment of a diverse congregation, which includes same gender loving couples, transgender couples, and people living with HIV. The church supports congregants with Hepatitis C and HIV prevention sex positive messaging that includes condom use, along with biomedical interventions such as PrEP/PEP and treatment adherence.

Findings and Recommendations

Some key recommendations for practicing radical inclusivity can be found in the Fellowship of Affirming Ministries’ (TFAM’s) mission and from Dr. Perness Seele, the visionary and founder of the Week of Prayer for the Healing of AIDS and Founder and CEO of The Balm and Gilead.

TFAM emphasizes the importance of creating a safe environment where all can assemble to:

- 1) Afford, both financially and socially, to tell the truth about ourselves and our congregations;
- 2) Become more inclusive in our theology; and
- 3) Create a network of collaborative support and practical guidance to prevent isolation and loss that typically haunt leaders and their churches as they become more radically inclusive (“Mission of Our Ministry,” n.d.).

Many faith leaders have historically had a strong voice and have supported social justice, poverty relief, and civil rights in African-American communities. However, many African-American churches “remain judgmental in their theology and are conservative in their politics toward same-gender loving people, people suffering substance abuse, people living with HIV/AIDS, the recently incarcerated, and sex-industry workers.” (“Mission of Our Ministry,” n.d.). It is important to acknowledge that African-American churches have a history of

embracing the culture of the oppressor by in turn oppressing people within their own community and by excluding and condemning those whom they don't like or approve of. Thus, African-American churches suffer from oppression sickness born out of slavery. Lastly, there is a growing movement of churches who are challenging theology by celebrating diversity with the inclusion of differences in sexual orientation, gender identity, and gender expression. As a result, there are often consequences to this work. Pastors and their congregations can pay a heavy price for "making courageous change." Members may experience intense divisions, and some may leave the congregation. The church's finances may decline. Positions of leadership may be removed, and pastors may be reassigned, with the sting of "social ostracism unleashed on the pastors and their congregations alike." ("Mission of Our Ministry," n.d.).

The movement toward radical inclusivity is timely because, as previously stated, African Americans and Hispanic/Latinx communities, regardless of their marginalized status or stigmatizing labels, are actively seeking traditional networks of support in communities of faith. In the height of the AIDS epidemic, Dr. Pernessa Seele encouraged faith leaders to acknowledge and respond to the lack of support being offered people with AIDS. The Black Church Week of Prayer for the Healing of AIDS, now in its 26th year, "has provided AIDS information to more than 5 million African Americans through the engagement of black congregations of every sector across the United States." ("Our journey — NWPCHA," 2015). Dr. Seele outlined lessons learned in addressing HIV prevention, stigma, and the role of the black church:

- Public-health models lack Afrocentric approaches and can be fiscally wasteful in communities of color.
- Some funded interventions are not sustainable in African-American communities and set providers up for fiscal droughts when funding cycles end.
- Intervention models need to continue to be developed within the African-American community by African Americans. African Americans know where to reach African-American MSM in the community and in the church, and it should be noted that those settings often are different from settings frequented by other groups.
- The Black Church Week of Prayer for the Healing of AIDS is a community-driven model — started with no funding dollars — and is a successful example of sustainability.
- Marginalized communities that construct cost-effective models still need funding and resources to maintain and expand projects that are effective in addressing HIV prevention, testing, and treatment.

The work of TFAM and The Balm and Gilead highlights the important role of faith-based communities in establishing community values related to sexual health and wellness. Successfully addressing HIV prevention and addressing barriers to care and treatment for people living with HIV requires participation from faith-based communities and faith-based leaders. Lastly, using the platform of the pulpit to address stigma is a powerful statement of care, support, and spiritual healing for those accustomed to rejection and discrimination.

Lessons Learned

The key lessons learned are

- Faith-based communities have a key role to play in HIV prevention in communities of color.
- Create a safe environment where people can speak openly.
- To ensure a buffer against potential alienation from conservative sources, create support systems and networks for organizations that become radically inclusive.
- Be aware of history, cultural context, and impact of internalized oppression.
- Be aware of the impact of historical marginalization due to institutional racism.
- Ensure that public-health models use a culturally responsive Afrocentric approach in African-American communities.
- Ensure that funded interventions are sustainable after the funding cycles end.
- Intervention models need to be developed within the African-American community by African Americans.
- Marginalized communities that construct cost-effective models still need funding and resources to maintain and expand projects that are effective in addressing HIV prevention, testing, and treatment.

Sources

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Case Study 8.

After a 17-year Ban, New York State Approves Medicaid for Transgender-related Healthcare Services



** It is important to note that while this case study references lobbying efforts in partnership with advocacy groups, federal funds were not and are not allowed to be used to lobby elected officials. Our CBA efforts must focus on education only.*

Issue¹³

In 1998, New York State Department of Health decided to single out transgender New Yorkers by blocking their access to Medicaid, the state's federal health insurance program for the poorest residents. At the time, the regulation, 18 NYCRR 505.2(l), stated, "Payment is not available for care, services, drugs, or supplies rendered for the purpose of gender reassignment or any care, services, drugs, or supplies intended to promote such treatment. These treatments for gender dysphoria are also known as transgender care" (Lewis, 2013). Not only was the regulation unconstitutional, violating Title VII of the 1964 Civil Rights Act, New York City human-rights laws, and state human-rights laws — all of which proscribe anti-transgender bias — it was also an example of policy that directs harmful exclusions that hamper HIV-prevention efforts.

The Centers for Disease Control (CDC) recognizes that various social determinants, including homelessness, unemployment, discrimination, limited healthcare access, and negative health-care encounters contribute to high rates of HIV for transgender people (CDC, 2016). Examples of limited healthcare access include a shortage of providers willing to provide medical care to transgender persons, a shortage of providers with experience or desire to learn about transition-related health care services, and cost of care. Research has shown that transgender women of color experience higher rates of HIV infection (Nuttbrock, et al., 2009), while HIV-positive transgender women in general experience lower rates of success with anti-retroviral therapy (ART) adherence (Sevelius, Carrico, and Johnson, 2010). Likewise, barriers to transgender-related healthcare, which include lack of access to medically monitored hormone therapy prompted by fear and previous negative provider experiences and cost, also complicate risk for HIV infection when people seek hormone treatment from street markets.

Target Population:

HIV Service Providers;
transgender services.

Geographic

Location:

New York State, USA

Social Determinant:

Policy/Law

Time Frame:

1998--2015

Sources:

Information was gathered from online resources and in-depth interviews with Legal Aid Staff, such as Attorney Belkys Garcia.

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The 2015 U.S. Transgender Survey, which examines the experiences of transgender people in the United States, the District of Columbia, American Samoa, Guam, Puerto Rico, and U.S. military bases overseas, reports that “respondents were asked about barriers to accessing healthcare, including cost of care, fear of being mistreated as a transgender person, and distance required to travel to see health providers for transition-related care” (James, et al., 2016). One-third (33%) of respondents reported at least one instance in the past year when they needed to see a doctor or other healthcare provider but did not because of cost. Additionally, nearly one-quarter (23%) of survey respondents reported avoiding seeking necessary healthcare due to fear of being mistreated as a transgender person (James, et al., 2016).

Project

The class-action lawsuit *Cruz v. Zucker* was the catalyst to repeal all transition-related care exclusions from 18 NYCRR 505.2(l). At the time *Cruz v. Zucker* was filed, a group of advocates consisting of transgender New Yorkers, transgender-led and focused organizations, community-based organizations, gay-rights organizations, law firms, healthcare providers, and allies had been supporting measures to change the regulation for more than a decade.

Community mobilization, advocacy and grassroots efforts were led by multiple groups: the Sylvia Rivera Law Project (SRLP), a collective organization that provides legal services for low-income transgender people and transgender people of color; the Audrey Lorde Project (ALP), a Lesbian, Gay, Bisexual, Two Spirit, Trans and Gender Non-Conforming People of Color center for community organizing; ALP’s TransJustice Project; GLAAD, a world-respected LGBTQ media advocacy organization; the Empire Justice Center, a statewide public-interest law firm who protect and strengthen the legal rights of poor and disabled New Yorkers; and Make the Road New York (MRNY) who work with Latinx and working-class communities to fight for justice and policy change. Together, this coalition collaborated and gathered the legal evidence and community support necessary to support *Cruz v. Zucker*. This included materials such as infographics, educational public-service announcements, and videos sharing perspectives from the transgender community, allies, and healthcare providers that challenged misconceptions about trans-health and highlighted the exclusion of trans-people from much-needed healthcare services (“THE LEGAL AID SOCIETY,” 2014).

In March 2013, The Transgender Legal Defense & Education Fund (TLDEF), a nonprofit organization who work to end discrimination and achieve equality for transgender people, submitted a 38-page letter strongly urging the state to rescind the 1998 regulation (Fund & Defense, 2015). In June of 2014, Health and Human Services, the agency that administers the federal Medicare program, reversed its own categorical exclusion of transgender health services. As a result, Medicare recipients could request coverage for gender-affirming hormones and surgeries on a case-by-case basis (Department of Health and Human Services, 2014). Building on this supportive momentum, SRLP, The Legal Aid Society, and Willkie Farr & Gallagher LLP (“Willkie Farr”) filed a class-action lawsuit, *Cruz v. Zucker*, against the New York State Department of Health on behalf of two transgender women who were denied medically necessary healthcare coverage by the State’s public health insurance because of a

discriminatory Medicaid regulation. (*Cruz et al v. Zucker, No. 1:2014cv04456 - Document 52 (S.D.N.Y. 2015)*, n.d.)

Results

In December 2014, Governor Andrew M. Cuomo announced that New York State's Medicaid Program would include healthcare services for Transgender Medicaid recipients, and, on March 11, 2015, the new regulation was officially adopted after a 45-day public-comment period. After a 17-year ban, many lauded the Governor's announcement as timely and commendable. This change also informed the NY State Department of Financial Service's issuance of their Circular Letter 7, which requires all private insurers administered in New York State to remove categorical exclusions for treatment of gender dysphoria ("Circular Letter No. 7," 2014).

Although this was a tremendous victory for transgender New Yorkers and advocates, barriers preventing access to Medicaid coverage and limitations for trans-related healthcare services still existed for youth under the age of 18. Under the *Cruz v. Zucker* case, advocates continued to seek coverage for youth requiring pubertal-suppression therapy (also known as hormone blockers), genital surgery for transgender people under the age of 21 years (which conflicts with NY State sterilization laws), and other medically necessary care which was not explicitly covered under the regulation. Further activism efforts included the collaboration of health-advocacy organizations and community-based organizations that both submitted comments with each regulation change and sustained pressure on New York State Department of Health to foster a more equitable regulation for transgender care. While the necessity for advocacy efforts continues, on December 7, 2016, New York State adopted a proposed rule to make Medicaid payments available for treatments that included transition-related medical care for transgender youth, including puberty blockers (Ennis, 2016).

Ongoing challenges

Despite the progress, significant challenges and barriers continue to impede transgender New Yorkers from accessing the benefits of the Medicaid regulation changes. One of the main barriers that exist for meeting Medicaid eligibility requirements is identification, as many transgender residents do not have identity documentation that match their new names and gender markers. Obtaining this documentation can be complicated, harmful, and costly to resolve. For example, transgender applicants are flagged as fraudulent in Medicaid enrollment systems, due to a gender and/or name mismatch. Although the U.S. Transgender Survey did not provide a detailed analysis of New York State, it does provide context for understanding the impact identification may have on accessing transgender-related healthcare services. "Most non-transgender people take their identity documents (IDs) for granted, but for transgender people, updating and using IDs may present substantial challenges" (James, et al., 2016). The national survey findings indicate ongoing financial, procedural, and eligibility barriers to obtaining IDs and records that reflect their gender identity (James, et al., 2016).

Similarly, transgender Medicaid recipients in New York continue to be denied routine care. For example, a transgender man may be denied coverage for sex-specific care because of how his gender marker is documented. Cervical pap-smear claims are often rejected without an “F” gender marker for the insurance enrollee. The national survey data shows 25% of respondents report insurance problems, including being denied coverage for routine care and/or care related to their gender transition. 13% further report being denied for sex-specific coverage, “including routine sexual or reproductive health screenings (such as pap smears, prostate exams, and mammograms)” (James, et al., 2016).

Although the case *Cruz v. Zucker* remains open to further improve the regulation, it exemplifies the need to be persistent, building coalitions across multiple stakeholders, and including members of the trans-community in efforts to create policy change. As Kinhead (2016) noted: “...legal victory is possible only because of the voices raised, the stories shared, and the fierce determination to fight back against injustice.”

Lessons Learned

The key lessons learned are

- *Collaboration and community mobilizing at multiple levels using multiple models are extremely valuable.*
- *As CBA providers cannot engage in lobbying and advocacy using federal funds, it is key to align with advocacy organizations to support these efforts. Years of long-term advocacy may be necessary.*
- *Partnering with medical providers was crucial in identifying types of denials being seen and experienced. Medical providers have been filing Medicaid appeals for decades to get coverage for their patients. Additionally, medical providers have a history of writing appeals, citing medical necessity and speaking publicly about the need to make healthcare coverage more equitable for transgender people.*
- *Identification of patients who were willing to step forward as plaintiffs in the case was critical.*
- *Monitoring implementation of regulation reform was important and will continue.*
- *Transgender New Yorkers, families, friends, and allies were key and strengthened the effort.*

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Further Resources

<http://hcfany.org/resources/comments-lgbt-task-force-comments-on-ny-medicaid-coverage-for-transgender-new-yorkers/>

<https://www.hhs.gov/programs/topic-sites/lgbt/accesstohealthcare/nondiscrimination/index.html>

<http://www.transequality.org/know-your-rights/medicare>

SRLP and GLADD

Infographic

<http://srlp.org/wp-content/uploads/2014/07/SRLPandGLAAD-Graphic.jpg>

SRLP and GLADD PSA

https://www.youtube.com/watch?v=kfzfUzU_574&list=PL0ihXOaL4A0U_sTH9eF37SEpygDD2n1xK&index=1

Case Study 9. A Holistic Approach to HIV Prevention and Treatment



Issue¹⁴

Newark is the largest city in the state of New Jersey (NJ), with a population of 281,944, of which 29.7 percent identified as living in poverty (U.S. Census Bureau, 2015). Newark is home to 15 percent of all those living with HIV/AIDS in NJ, and is a municipality of Essex County, which has the highest number of people living with HIV/AIDS (14,919) in the state (NJDOH, 2016). The North Jersey Community Research Initiative (NJCRI) opened its doors in 1988 and began its HIV-testing work in 1995, following the 1992 spike in NJ HIV incidence rates — the highest single-year spike in the history of the HIV/AIDS epidemic in NJ (O’Dea, 2014).

Project

NJCRI was the first AIDS service organization in New Jersey to provide medical care to those with HIV and began as an effort to eliminate the access-to-care barrier faced by New Jerseyans living with HIV/AIDS early on in the epidemic. In the late ’80s, NJ residents looking to gain access to new and promising HIV/AIDS treatment clinical trials had no other option but to travel to New York City.

Throughout their almost-30-years of service to the residents of Newark and the greater North NJ and NYC areas, the team at NJCRI has made tackling social determinants of health part of their continuous quality-improvement efforts. Since many NJCRI clients were, and continue to be, those struggling with issues of financial burden, homelessness, unemployment, lack of transportation, and co-occurring illnesses, NJCRI quickly responded by adopting a “one-stop shop,” holistic approach to prevention and care services. As part of this holistic approach, clients have access to a number of ancillary services, which have expanded to include the following: laundry services, clothing and food pantries, showers, living and dining rooms, internet café, syringe exchange, an on-site pharmacy, and career academy.

In an effort to address co-occurring illnesses and other medical conditions impacting their clients, NJCRI now offers the following medical and behavioral health services: Substance-use treatment, behavioral-health counseling, support groups, gynecology,

Target Population:
Low-income individuals at high risk for HIV and living with HIV/AIDS

Geographic Location:
Newark, NJ, USA

Social Determinant:
Poverty

Time Frame:
1995 – Present

Source:
In-depth interview with Corey Destefano, Clinical Director at NJCRI, conducted by Vanessa Arias-Martinez, PROCEED, Inc. in September 2016.

¹⁴ Authors and contact for this case study are Vanessa Arias-Martinez and Miguel Taveras, Proceed, Inc. Email: [Miguel Taveras](mailto:mtaveras@proceedinc.com) at mtaveras@proceedinc.com.

primary care, infectious-diseases treatment, nursing, dentistry, pediatrics, and a fitness center complete with equipment and a professional volunteer trainer.

The main focus for NJCRI has been to eliminate many of the structural barriers adversely impacting their clients' ability to access and adhere to their HIV prevention or HIV/AIDS treatment services. Delivering this wide range of ancillary services developed the need for the organization to implement an improved communication system. As a result, NJCRI now uses an electronic records and check-in system, which allows the various departments working with a single client to be notified when their clients are on-site for any other service. This helps to ensure a client is less likely to miss an appointment and can have ongoing and consistent access to their entire treatment team.

NJCRI's primary approach to assessing the needs of their community in order to develop appropriate programming has involved biannual client-satisfaction surveys, annual focus groups, and weekly suggestion-box collections. Financially, NJCRI has been able to continue expanding their services by diversifying their funding sources. In the last two years, NJCRI has begun offering billable services into their organization's business model.

Results

Embracing the "one-stop shop," holistic model has helped to decrease the stigma around accessing NJCRI services, as it is no longer considered an "HIV-only" service provider. This has further increased the utilization of ancillary services among clients accessing HIV-treatment or HIV-prevention services.

NJCRI's use of an electronic records and check-in system has increased communication among staff for improved delivery of comprehensive services. Grant-funding now helps to support services for undocumented clients, who are ineligible for insurance, while revenue generated from billable services has afforded NJCRI a more sustainable and flexible service-delivery model.

NJCRI's client statistics show a sustained high rate of treatment adherence (approx. 93–94% in 2016), an average of 3,500 individuals tested for HIV, Viral Hepatitis, and other STDs, annually, and a 2% seropositivity rate. In the past year, 100% of those identified as a **PLWHPWHA** were linked to care, 96% of those identified as high-risk negative individuals were linked to prevention services, and all received these linkages on the same day of initial service.

Lessons Learned

The key lessons learned are

- *Having an ongoing flow of communication from clients to staff to leadership is critical in order to properly meet the needs of the population, and board buy-in is also critical.*
- *Using a billable-services model allows the organization to no longer solely depend on grant funding, therefore improving the sustainability and flexibility of their programs and services.*
- *Offering an array of non-HIV related services can help de-stigmatize a HIV-service organization, thus increasing the number of people seeking services.*

- *If your organization is not equipped or able to offer a wider range of services, it is important to establish memoranda of understanding (MOUs) with outside providers in the community; NJCRI has MOUs with more than 60 different organizations throughout NY and NJ to ensure easy and direct referral processes for NJCRI clients.*

Sources

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Summary of Lessons Learned and Implications for Training Around SDH¹⁵

This section summarizes some key themes from the lessons learned and offers some implications and recommendations for training around SDH. Two strategies based on ongoing best practices are highlighted to support policy development that integrates SDH and a tool to include SDH and facilitate robust community-resource referrals. As previously noted, the SDH workgroup is currently developing materials to support the use of this document and case studies. This document serves as an overarching guide for those interested in learning more about specific and diverse ways in which states, counties, organizations, and communities are addressing SDH in the U.S.

While this list is by no means exhaustive or hierarchical, key themes, implications, and recommendations that emerge from the case studies outlined include:

HIV prevention efforts must include structural interventions:

We cannot end the epidemic by focusing only on individual behavioral change. This ignores the systems of oppression and privilege that can facilitate or hinder access to, and engagement in, prevention and care.

Funding is critical to mobilizing states into addressing SDH:

Grants that mobilize states into addressing SDH are critical to enable resources to be devoted to addressing structural barriers to care and to demonstrate the impact of these interventions on HIV prevention and care.

The need for leadership and buy-in:

Whether the level of intervention is the community, an organization, or the state level, there is a need for a person of influence to champion efforts. Clear communication from clients to staff to leadership is essential. Leadership involvement and buy-in by staff, the community, organizational boards, and other stakeholders are critical to effect change. An internal champion-mobilization strategy can support this.

Crucial conversations are critical to effect real and sustained change:

We cannot effect real and sustained change without acknowledging and examining privilege and taking time to meaningfully and critically engage around the intersection of issues such as institutional racism, homophobia, transphobia, and gender inequality.

¹⁵ Author and contact for this section is Deena Murphy, CPN Resource Center (CRC). Email: [Deena.Murphy](mailto:Deena.Murphy@cpnresourcecenter.org) at deena@cpnresourcecenter.org.

Cultural humility requires crucial conversations around privilege and oppression, ensuring that we recognize the ongoing impacts of slavery and the history, cultural context, and impact of internalized oppression. This requires us to recognize power imbalances in meeting spaces and to create a safe environment where people can speak openly.

Coalitions should include multiple and diverse stakeholders:

It is essential to ensure that multiple and diverse stakeholders are engaged in any collaborative efforts to effect change and reach health equity. This requires us to build partnerships and coalitions between communities and healthcare organizations, between public health and government, and between clients and medical providers. All stakeholders can learn from each other and support restructuring efforts to ensure that they are inclusive of all voices and can make healthcare more equitable. This means those from the priority populations must also be placed in positions of influence and have leadership roles, so their voices can be heard.

Community-based participatory interventions are key to sustained change:

For community programs to be sustainable, we need buy-in, engagement, and ownership by communities. Partnering with communities is essential to mobilize the community and foster ownership among coalition members. This requires engaging community (or staff for an organization) from the very beginning, involving them in project design, ensuring that designs are culturally responsive, ensuring that intervention models are developed in partnership with the community, and building the capacity of the community to implement and sustain any interventions.

Funding and programs should be developed in a way that enables sustainability for the community:

Identifying ways that funded interventions can sustain themselves after the initial funding cycle ends is critical and needs to start early in the process. Historically marginalized communities that construct cost-effective models may still need ongoing support and resources to maintain and expand effective projects in addressing HIV prevention, testing, and treatment. Strategies such as using a billable-services model so the organization or community no longer relies on grant funding can improve the sustainability and flexibility of programs and services. It is also critical to note that funding may come from diverse sources, so building capacity to raise funds and looking for diverse funding sources are critical.

Be strategic in community-based HIV-prevention and -care approaches:

Due to ongoing stigma, it may be easier to gain access to a community and local government support if we focus on related issues, rather than the specific social determinant that needs addressing (e.g., bullying and violence versus homophobia). Organizations can offset the stigma associated with HIV by offering an array of non-HIV related services, which increases the number of people seeking services. Organizations that are unable to offer wider ranges of services can establish memoranda of

understanding (MOUs) with outside providers in the community. This ensures easy and direct referral processes.

Visibility matters; be persistent and patient:

If we are seeking to effect change in a community or to access and educate¹⁶ governmental leaders, it is critical to be visibly present and have consistent messaging. This includes having a strong online presence and ensuring materials and resources are easily accessed. Organizational and policy change can take time, and long-term advocacy may be necessary. Following up after meetings, trainings, and workshops is essential. Some of these issues are content heavy and require people to have time to practice reflective inquiry and to process. We should not rush to solutions before fully examining privilege and practicing cultural humility.

Effective programs and structural policy changes are interdependent:

An effective policy supported by organizational practice and support creates change. If organizations require providers to include LGBTQ competency and updated providers on high-impact HIV prevention, it leads to more effective programs and practices. Similarly, programs that demonstrate effectiveness create data to support new policy at both the organization and state levels (creating further structural changes). It is not enough to have policies in place, however — we must also monitor implementation of policies and practices on an ongoing basis.

Programs can retain fidelity to core components yet remain adaptable to community context:

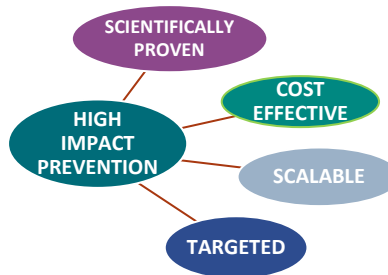
Effective interventions are designed with core components that, if implemented well, result in successful outcomes. However, it is important to find a balance between adhering to the core components of the model while also ensuring that the program is adaptable to various settings and can be scaled down for the time length available. Using examples specific to the population involved and practicing cultural humility is critical to ensure that local conditions are included. Training members of the engaged community to administer programs and lead is a key strategy that supports this.

¹⁶ It is critical to note that federal funds cannot be used for lobbying efforts. Instead the CBA focus must be on education and training. Partnering with advocacy groups not funded by federal agencies can be a useful approach (as long as no federal funds are used).

Strategy 1: Policy Development to Integrate Social Determinants of Health into High Impact HIV Prevention Service Delivery

Issue¹⁷

Providing high-impact HIV prevention (HIP) service delivery, inclusive of social determinants of health (SDH), often requires revising policies or developing new ones to support innovative strategies, new focus areas, new populations, or new activities. Implementing supportive policies is particularly important when addressing social determinants of health for populations that are overly burdened by HIV. Agencies and organizations may be aware of the influence of SDH on the lived experience of their consumers, but may be unaware of how to augment or change their current policies to address these needs. Typical examples include when an agency begins service delivery to new and unique populations or when incorporating social determinants of health into the overall HIV service-delivery process. Agencies adding new services, in response to social determinants that affect focus populations, may need to develop or augment referral or collaborative agreements with partner agencies, thus requiring updates to current policies or developing new ones.



Strategy

Implementation may occur in multiple ways, including accessing available literature to understand and replicate best practices for policy development, requesting capacity building assistance (CBA), or obtaining peer-to-peer assistance from partner agencies that have already addressed these policy developments and implementation needs.

Policy development may occur using any of the following processes:

- Conducting formative assessment with members of the new focus population and opinion leaders in the community and accessing stakeholders to understand key perspectives, needs, and available or required resources.
- Reviewing and critiquing current policies to determine where to make changes to integrate social determinants of health into HIV service delivery.
- Accessing policy-development guidance and resources to determine best practices for creating new policies.

¹⁷ Author and contact for this section is Arlene Edwards, Centers for Disease Control and Prevention (CDC). Email: [Arlene Edwards at eur1@cdc.gov](mailto:eur1@cdc.gov).

Recommendations

Policy development to address the integration of SDH service-delivery needs should occur prior to attempting to provide services that would require new agency guidance. Information is listed below that may guide integrating SDH into HIP service delivery.

A key best practice for policy development is the 8-fold path (Bardach, 2012; 2016; Strahan, 2016)

1. **Define the Problem** — Keep the definition as clear and precise as possible.
2. **Assemble the Evidence** — Assess the nature and extent of the problem, features of the policy situation, and other policies that worked well in similar situations.
3. **Construct the Alternatives** — Begin with as many options as possible and refine toward what can be done.
4. **Select the Criteria** — Objectives or standards to ensure that the projected outcome will produce a policy to solve the problem at an acceptable level.
5. **Project the Outcomes** — Understand what changes will occur because of the alternatives that are chosen and who will be affected by the changes.
6. **Confront the Trade-offs** — Review advantages and disadvantages of each alternative, and identify which alternative is predominant overall.
7. **Decide** — Choose an alternative that will address the problem.
8. **Tell Your Story** — Present the issue and proposed policy in a manner that is easy to understand and tailored to the anticipated audience.

Completion of these steps should result in readiness to implement the resulting policy that was created to address social determinants of health.

Sources

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Strategy 2: Developing Robust Community Referrals to Address Social Determinants of Health



Issue¹⁸

Within the practice of HIV-prevention service delivery, there is a need for attention to social determinants of health, as a means of augmenting current interventions (Dean and Fenton, 2010; Dean, Williams, and Fenton, 2013; Crepaz, et al., 2015) and also as a means of attending to key factors that affect an individual's ability to participate in ameliorative services (Auerbach, 2009). Therefore, implementing high-impact HIV prevention (HIP) service delivery could simultaneously involve accessing multiple resources beyond the scope of implementing a specific intervention or strategy. Proactive access may occur based on knowledge of the unique needs of a focus population. Retroactive access occurs after a need is observed and is usually based on information that is provided during recruitment, screening, or formative data collection on a focus population. Addressing these social determinants is important, especially since they can influence successful participation in a particular intervention.

Strategy

A robust community resource-and-referral list is a useful strategy to address social determinants of health in a proactive or retroactive manner when providing HIP-focused, evidence-based, HIV-prevention service delivery. Given the unique social and demographic characteristics of many focus populations who are at risk for HIV (MSM and women of color, transgender women), as well as the inherent diversity of cultural and contextual behavioral norms, it is most useful to develop a referral template as a best practice. This template could serve as a framework for implementing agencies to create a robust referral-and-resource list that can address the social determinants that their focus populations experience. Thus, organizations that typically engage focus populations for HIV-prevention service delivery, whose lived experiences are influenced by social determinants, may use the template to tailor and complete a list to meet the needs that they observe.

Process

The template should focus on social determinants that typically affect individuals, at the local level, who are at risk for HIV, and for whom these determinants would influence their participation in and benefit from an HIV-prevention intervention or strategy. Additional focus should be given to populations considered "hard to reach" or who are simultaneously affected by health inequity based on their social demographics (Poteat, Reisner, Radix, et

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al., 2015). Therefore, the template should include information on resources related to transportation, employment, housing, local food banks, clothing, economic assistance for key items such as housing, medicine, hormonal treatment, food, etc. Access to these resources may be developed through collaborative partnerships (Dean and Fenton, 2010). Referrals should specifically include the names of organizational staff who are able to commit resources or services to assist members of a focus population who are referred to their organization. The template should include enough detail for follow-up to occur on behalf of the recipient.

Recommendations

The template listed below reflects key components that should be included in a resource-and-referral list that specifically reflects SDH. The availability and locations of resources may be determined by conducting brief interviews with members of a focus population to determine where they obtain services, who provides the services, and any other pertinent information. Agencies developing an SDH referral list should contact partner organizations to determine additional available resources, contact individuals, costs and requirements for their use (e.g., delivery times, key services). Referrals should be made to organizations that are vetted by members of the focus population.

Resource: What social determinant is the referral for? For example: Housing, Employment, HRT, Transportation, Economic Assistance, Food, Mental Health Care, Health Care, Employment Training		
Description: What are the key characteristics of the resource? For example: Is the housing near local bus lines or the Metro? Is transportation nearby (bus/train routes)? Are clothing and personal items provided?		
Availability: 7 days a week? Weekends? During business hours only? 24 hours?		
Client Population: Key demographics: For example, young MSM of color who are emancipated minors; transgender women who are sex workers; transgender women only		
Contact Name:	How was this contact vetted? Phone call? Email? Text?	
Address:		
Phone: Office:	Cell:	Other:
Date of Referral:		
Date of Follow-up:		

Sources

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