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ADVANCING HEALTH EQUITY IN HIV PREVENTION AND TREATMENT: THE NYS HIV PRIMARY CARE AND PREVENTION ANNUAL CONFERENCE

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Advancing Health Equity in HIV Prevention and Treatment: The NYS HIV Primary Care and Prevention Annual Conference

[video transcript]

00:09
Dr. Oni Blackstock is founder and executive director of health justice. A consultancy that supports health related organizations to center anti racism and equity in the workplace, and to reduce health inequities in the communities they serve. She's a primary care and HIV physician and is recognized as a thought leader and influencer in the areas of HIV and health equity. Dr. Blackstock previously served as the Assistant Commissioner for the New York City Department of Health and Mental Hygiene, where she led the city's response to ending the HIV epidemic. Prior to that she was an assistant professor in the division of general internal medicine at Montefiore Medical Center, Albert Einstein College of Medicine, where she provided clinical care and conducted HIV clinical research. Within the healthcare and public health arenas, Dr. Blackstock has developed and implemented racial equity programs and initiatives, including establishing the first Bureau based racial equity program at the New York City Health Department, which have led to improve workforce equity, and more equitable administrative and programmatic policies. Additionally, her own experience living at the intersection of several marginalized identities has informed her deep commitment to advancing health equity. Dr. Blackstock holds degrees from Harvard College and Harvard Medical School and Yale School of Medicine. She has been the recipient of awards and recognition for media outlets such as Marie Claire, go out in Essence magazines, and community-based organizations such as calendar, a community health center and exponents. She has made multiple media appearances a critic sharing her expertise of Democracy Now CNN, MSNBC and Good Morning America. Today, Dr. Blackstock will be presenting advancing health equity and HIV prevention and treatment. Welcome Dr. Blackstock.

01:56
Thank you so much, Jessica. And thank you to CEI, for the invitation to present this plenary. Before I begin, I just want to make space for you know how people might be feeling with the announcement of the Supreme Court overturning Roe v Wade. I think people may be experiencing many different feelings. So just want to take a moment to recognize that and then to say, what I saw Mariame Kaba who is a well-known abolitionist, tweet out today saying, focus, to channel our energies towards lessening suffering and to let occurrences like this radicalize us rather than lead to despair. So, just to say, for those of you who may be in grieving or in despair today, sit in those feelings. And tomorrow, we're going to hopefully push forward. And much of the spirit of that is really in line with hopefully, some of the information that I will be sharing with you in this talk. So, I have no disclosures.

03:06
The learning objectives for this talker to very briefly, I'll be describing HIV related inequities. Hopefully after this talk, you'll be able to recognize the major structural drivers of HIV related inequities, be able to define structural competency and identify strategies to advance health equity and HIV prevention and treatment. And the roadmap for the lecture sort of mirrors those

objectives, again, touching briefly on HIV related inequities, speaking to the structural determinants of health and structural competency, and then covering some strategies around advancing equity.

03:47
So, those of you who've seen me talk before may remember, I always start with Robert Reyford. And so, I asked you have you ever heard the name? Robert Rayford. So, in 1968, a 15-year-old black teenager checked himself into a St. Louis hospital months later in 1969, at the age of 16, he would die of complications of what would later be attributed to HIV. His name was Robert Rayford. And as a now he is the earliest identifiable person to have lived with HIV in the United States. And little else is really known about Robert yet beyond the fact that he lived with his mother and his brother on Del Mar Boulevard and St. Louis Del Mar Boulevard was known as a dividing line between the city's wealthier white residents and its poor black residents. He was referred to often as Bobby and described as painfully shy, quote unquote, mentally slow, maybe even intellectually disabled, quote, unquote. And at the time that he presented for care of he was diagnosed with a severe chlamydia infection. Being a black child, unfortunately, it was assumed that he was involved in sex work. Although we know children cannot consent to that, it was not assumed that he was likely a victim of childhood sexual abuse. And it would later be discovered in 1987. Almost two decades later, when specimens from his body were tested, that he was likely the first known case of HIV. And I mentioned Robert staying because even though I had been in the field of HIV for a decade and a half, I only learned about Robert, a few years ago.

05:38
And so, when I think about the invisibility or in many ways, the ratio of Robert story it also makes me think of how the disproportionate impact of HIV on black and brown communities wasn't visible eyes at the beginning of the AIDS epidemic. And this is highlighted very nicely by Professor Kevin Moseby in his article two regimes of HIV AIDS, which I recommend everyone read. So, even when we go back to the first AIDS case reports in MMWR, published in June 1981. The text describes five, quote unquote homosexual men who presented with a rare pneumonia, their race ethnicity was not identified, was not specified. These five men were white. Subsequently, other cases occurred among black men. But that was never mentioned. And it was a point that the white male doctor who diagnosed a number of these cases, thought was no big deal not to mention the race of the individuals impacted. Also, the first case reports of HIV among cisgender women were among a black woman as well as a Latina woman. However, it wasn't until about five years into the AIDS epidemic that the CDC began to finally, report on the disproportionality of the epidemic on black and Latinx Americans. And basically, that this data was not shared or highlighted earlier, gave the impression that HIV was only a condition that affected gay white men. And this resulted really the lack of attention and investment early on and addressing HIV in impacted communities. And so, we've come very far since then, we now have a potent what you know, once a day treatment regimen, we have highly effective once a day pill to prevent HIV, improve quality of life for many people living with HIV. And we you know, overall seen a substantial decline in new diagnoses. However, inequities in many ways have become even more pronounced. So, just looking at new HIV diagnoses, and we see that black and Latino Americans account for 42%, and 29%, of new

diagnoses, although these groups account for 13 and 19%, of the US population, respectively. And we know that in particular, black and Latino men who have sex with men and black and Latina, cis and trans women are disproportionately impacted. So again, when we look at this data, which I'm sure many of you are familiar with, we see black and Latino men accounting for the largest number of new HIV diagnoses, and among women, black cisgender women, account for the highest number of diagnoses. And then similarly, we see similar trends when we look at people of trans experience. When we look at trans women, you know, black and Latino women accounting for the majority of new diagnoses and black trans men accounting for almost half of new diagnoses among trans men. And we see the same inequities in PrEP coverage and in the HIV care cascade. So, this is looking at PrEP coverage for those 16 years and older in 2018. And it's as you can see about 18% of those with indications for PrEP are receiving PrEP. The when we look at that broken down by race ethnicity, we see that 42% of what people with indications for PrEP are receiving it compared to just 11% for Latino Americans and 6% for African Americans.

09:30
So just moving on, so with these inequities in mind, you will remember that there's the federal ending the HIV epidemic initiative that really is seeking to reduce new HIV infections by 75% by 2025, and then by 90% by 2030. And so, while it's really heartening to have this infusion of resources to end the epidemic, the initiative really has no explicit targets, or indicators for reducing racial or ethnic disparities and really no mention of racism or the other systems of oppression such as homophobia, and transphobia, that drive these inequities. In response to this sort of absence of attention to racism and other drivers of HIV inequities, the black AIDS Institute released we the people of black plan to end HIV, which I strongly recommend reading. And then a group of Latino academicians and community partners wrote about the invisible Latino HIV crisis. And really what these papers really drove home was that HIV is not merely a public health issue, but a racial and social justice issue. And we can see, unsurprisingly, with this modeling study analysis that found that time to the end of the HIV epidemic really varies by race ethnicity. So, as you can see, just looking at the upper left hand corner graph, which is New York City, there's a gray line horizontal line that goes across and it's that gray line represents a level below which HIV is no longer at epidemic levels. And for New York City, as you can see, the darker sort of dotted line representing Latino New Yorkers and then sort of the irregularly dotted line representing black New Yorkers, you can see that even as far out as both 2030 and 2040, and we will have not reached non epidemic levels among those populations. While when we look at the line representing white new yorkers, we're ready below epidemic levels of HIV for it for that population. These estimates were again made pre COVID. So, it is much more likely that it will take longer to end the epidemic among black and Latin X communities due to the COVID 19 pandemic.

12:05
Since the ending the epidemic initiative was introduced, we have fortunately seen greater recognition of racism as a public health crisis and its contribution to HIV related inequities. This is the national HIV AIDS strategy, which explicitly calls out reducing HIV related disparities and health inequities, and calls out the system of racism as a structural driver. And I think what probably led to this increasing recognition we know is the murder of George Floyd and the

subsequent uprisings that occurred that really raised the spotlight on health inequities in the United States. So, just to make sure we're all on the same page, what do we mean when we say systemic racism. As many of you may know, racism can act at different levels at the interpersonal level, can be internalized institutional and structural level. But most important is that it operates as a system. So, it operates regardless of individual intent. And I like this definition that Dr. Camara Jones uses, she says, racism is a system of structuring opportunity and assigning value based on the social interpretation of how one looks, which is what we call race that unfairly disadvantages some individuals and communities and barely advantages other individuals and communities, undermining realization of the full potential of the whole society through the waste of, of human resources. And we know that racism intersects with other systems of oppression, like sexism, classism, homophobia, transphobia, etc. And these intersecting systems represent intersecting systems of marginalization and can further compound risk.

14:07
When we think about the root cause of health inequities, including HIV, we know that poverty and social and economic inequality drive health inequities. What drives poverty and inequality? These are structures that do policies, economic systems, social hierarchies, like racism that have produced and maintain social inequities, then contribute to health inequities. And these structures all interact with one another, reinforcing one another. And so, what they really represent are the structural determinants of health, often we've heard about the social determinants of health so the structural determinants of health, operate through the social determinants as being, you know, the housing, workplace, work environments, social support, food availability, physical activity, and they work through these to shape health outcomes. And I think often of the structural determinants of health as really the foundation, or the scaffolding for the social determinants of health. What are some of the structural drivers of HIV, for black and Latina, cisgender, and transgender women? In terms of social hierarchies, we know that there's that racism, sexism, and transphobia. All contribute. Racism contributes to discriminatory housing, and lending policies that promote racial segregation, and a particular residential segregation that has really led to broad disinvestment, and concentrated poverty and black and Latino communities.

15:57
Also, lack of access to quality health care, including gender affirming care plays a role. We know that, that this is further compounded by the fact that there's occupational segregation, that has really concentrated black and Latino people in particular, women in low paying jobs with limited health benefits. So, black Latino people are much less likely to have health insurance. There's also been really broad disinvestment in terms of community hospitals, and black and Latino neighborhoods, and all of these work to impact lack of access to quality health care. And I should just go back also just to say that providers also play a role in contributing to these, to these inequities. And there was a recent study that was published looking at provider bias and the provision of PrEP to women, so provider willingness to prescribe PrEP to black women. And they found that providers with high scores on a racism measure were actually less willing to discuss and, and prescribe PrEP to their black women patients. And the found that this was this was mediated by providers perceptions, about patients' ability to adhere to PrEP. So, providers

with higher racism scores were more likely to believe that black women were not going to adhere to PrEP, and therefore they were less willing to talk with their black woman patients about PrEP. We know that mass incarceration plays a role in terms of limiting the number of available partners, it also disrupts families and communities. We also know gender-based violence plays a role as well, as well as policies that criminalize sex work. And all of these factors also impact your ability to engage in HIV care and treatment as well. And they result in concurrent partnerships where we see you know; one person might be in relationship with multiple different people. And this can be a driver of HIV and STI transmission. We also see disassortative sorting. So, you may have someone a woman who may be at lower risk having a partner who may be engaged in higher risk behaviors. Again, high higher STI prevalence, and then power differentials that impact women's ability to negotiate safer sex practices. So, all of these contribute to higher HIV risks and challenges with engaging in care and prevention.

18:24
What about if we look at black and Latino, same gender Latin men, and again, this is not an exhaustive list, there'll be factors that I will inevitably have left off. So, thinking about racism and xenophobia, homophobia, including internalized homophobia, and stigmatization within one's own racial community, the broader society as well as the white gay male community, and then HIV stigma. And again, you know, racism, again, contributes to racial segregation, including within sexual networks, which then concentrates against HIV prevalence. It also impacts poverty, lack of access, again, to quality health care, because of lack of access to quality health care, we see that black and Latino men who have sex with men are less likely to know their HIV status and if they're HIV positive, less likely to be in care, and on medication, which again, elevates community and sexual network viral load. Mass incarceration, there's actually very limited data on how much of the US Black MSM population has been impacted by incarceration. However, HPT 061 HIV prevention trials network, 061 study found that in their sample of about 1400, Black MSM that about 60% had a history of incarceration. There's also HIV criminalization, which is really a form of anti-black structural homophobia, that targets primarily black gay men, which I will talk about a little later on in which drives HIV stigma. And then it's really interesting, there are studies that show that racism and homophobia, experiencing those, and the stress of those can have direct effects on behavior. So, there was a study that showed that black and Latino and Asian men who have sex with men, that stress due to racism within the gay community was found to be significantly associated with engaging in condomless anal intercourse as well. And these all lead to contribute to higher rates of STI, and higher prevalence of undiagnosed HIV.

20:47
So, just going back to, you know, we've talked about a little bit about these structures and their impact on the day-to-day experience of black and Latino people and the overall health of people living with HIV. And so, as healthcare providers, it's really important and really critical that we understand how these structural factors impact, you know, the lived experiences, you know, of our patients, whether we may be engaging with them around HIV prevention, or treatment. And so, it's critical that we move beyond this idea of just cultural competency, which often relies heavily on sort of stereotypes of different groups, and doesn't really recognize the contribution of these structural factors that we move from cultural competency to something called structural

competency. Structural competency is the capacity for health professionals to understand to recognize and respond to health and illness as downstream effects of broad social, political, and economic structures. And so, for this latter part of my presentation, I'll focus on strategies to develop structural competency at these various levels. We can develop cultural competency at the individual level, all the way up to the policy level. And I'll be sharing with you just a potpourri of strategies. So, just see if there are one or two that might resonate with you that you might want to try out. Again, it's not an exhaustive list, and during the Q&A, we'd love to hear about any strategies or initiatives that you are using in your practice to address HIV related inequities.

22:34
What can you do at the individual level? Start with educating yourself about racism and other systems of oppression and how these systems lead to practices and policies that increase vulnerability to HIV for black folks, for Latinx folks and for people from other marginalized groups. Cultivate something called structural humility. This is a key aspect of structural competency. Structural humility, it's basically sort of orientation or posture that emphasizes collaboration with our patients, with the with our communities that we're serving with community partners and developing responses to structural vulnerability. Rather than assuming that as health professionals alone, we have all the answers. And this also includes us awareness of our interpersonal privilege, and the power hierarchies that exist, and that can show up within our interactions with our patients in the healthcare setting. And then also practicing self-accountability. What does that have to do with anything why practice self-accountability? Self-accountability is really a building block for mutual accountability for community accountability. And it's like actually a key building block of anti-racism movements and anti-oppression movements. I really like the definition that Danica Bornstein uses about accountability, accountability is being responsible to yourself to those around you for your choices, and the consequences of those choices, choices. And so, I think of self-accountability as this sort of ongoing, self-reflective process that really remembering our values, that if we're committed, we've committed harm, even if unintentionally, we've said something racist, or sexist or homophobic or transphobic that we seek to understand, you know, what was going on with us at the time? What was like sort of around the context of harm? And what do we need to do now to prevent that from happening again. And so, practicing self-accountability is something that, you know, is often you know, encouraged as we work towards dismantling many of these systems. So, what can you do at the interpersonal level? I like to start with saying, you know, when we're with our patients or clients, coming from an orientation of what matters to our patient versus what's the matter with them? What matters to them is about really prioritizing their needs, their motivations, their desires, versus really oftentimes pathologizing our patients and saying kind of what's wrong with you. Again, eliciting experiences with racism or other systems of oppression that our patients might have had. And also affirming and understanding how these experiences may affect their engagement and care. Just focusing a little more on those. In terms of centering and affirming our patients' experiences, this can, I think really be important and help with building trust and being in right relationship with our patients? Asking questions, like, you know, many of my clients, patients experienced racism or other homophobia while receiving health services. Are there any experiences that you would like to share with me, you know, can be as simple as What have your experiences, what the healthcare system been, like, or seeking services has been like, have you had any experiences that caused you to lose trust? and really

work on acknowledging and affirming and validating when patients have shared their experiences. And so, it's really important that as providers, we acknowledge realities, both historical and current that may have led to a patient's should have been mistrustful, including that person's own experience that they've had both within and outside of the healthcare system. And what that can do is it can really by validating, it really communicates to our patients, that whatever thoughts or behaviors or emotions they have, are well grounded, that they are justifiable and relevant and valid.

26:52
And then another thing that's really important is, you know, once someone has shared with us, you know, their experiences, that we then ask for permission to share information, once we've validated their concerns. And, you know, addressing issues around trust are really important. There was a recent study looking at the way that structural racism shows up in HIV care for black and Latino patients. And it found that distrust of medical institutions, and health care providers lead to the feeling among many patients that they were being pressured to take HIV treatment, when it was offered. And they patients perceived often that they were excluded from any sort of decision making that occurred during their visits with their providers. And that often, HIV treatment was over emphasized, compared to other non-HIV related priorities. So, it's really important, again, building trust, especially as we have shifted to models of immediate, you know, HIV treatment, same day PrEP, that we are working to really to build relationships with our patients so that they feel safe.

28:04
And so just moving on, just I've had mentioned before a number of the structural drivers. And so, it's important also to think about, you know, is there a role for discussing these different structural providers, you know, during the patient provider interaction, do patients actually want to hear about this. And we sort of explored this in an article that I co-wrote with colleagues, about reimagining the way that PrEP is provided to cisgender and transgender women in the US using a structural lens. So, when it comes to PrEP care, there have been advocates who really propose looking at structural vulnerability assessments as ways to measure how structural factors like poverty, mass incarceration, impact people's ability to engage in health care, and to protect themselves. But beyond that, there is not a lot of data about whether patients really want to hear about sort of these sort of higher-level factors. And so, in a study that one of my co-authors Dr. Rachel Logan, conducted with black women from communities of high HIV prevalence, they found that sharing information on the structural drivers the structural determinants of health, with patients, that some patients did find it empowering, but others felt like they were being singled out and stigmatized. And only a minority of respondents really preferred talking with the provider actually, most actually preferred to receive the information in a handout. And then on the other side, liberals known about how willing providers are you may reflect on this to discuss how willing providers are around discussing the structural determinants with patients so there's much more work that needs to be done as to you know, what these conversations might sound like with patients, and how do we maybe approach these discussions in a way that is both culturally and instructionally competent. So, what can be done at the organizational level. There are many, I think, really excellent models that are out there. And that are designing designed to really mitigate and address the effects of racism and

homophobia. And again, we'd love to hear about any that you were involved in during the q&a. In my work, when I was an assistant commissioner at the New York City Health Department, we held a number of sorts of listening sessions with black and Latino men who have sex with men to understand more about what they were wanting in their service providers. And so, I'm just going to share a few select themes that came up. Many one had mandated trainings for all staff, and you know, from leadership, all the leadership to front desk staff. This was based on stigmatizing experiences that they had, you know, with front desk staff, with providers and other members of the care team.

31:04
They also wanted to see a more central focus on using multiple, sort of multiple modalities and multiple strategies to provide mental health services to MSM, so using telehealth using mobile vans and other forms of outreach as well, there was also a desire for healing centered engagement, which is a shift away from trauma informed care, which often sort of pathologizes the person sort of makes the person the trauma as opposed to really understanding the context in which the person is living. And, you know, creating an environment in which the patient is allowed to heal from the trauma that they've experienced, as well as pleasure-based approaches. So often, sex and particular sex between men is so heavily stigmatized that there's little discussion of pleasure when discussing HIV prevention and treatment. And so, there's a desire for pleasure to be incorporated into these discussions when patients see their providers. And then lastly, support for professional development and creation of intentional employment and leadership pathways for Black MSM. We know representation at all levels of an organization is important for people from marginalized communities to feel affirmed, to feel comfortable to feel seen. And so, these were some of the recommendations provided.

32:33
So, there actually isn't a whole lot of research that of studying different, these different set of approaches specifically focused on, you know, addressing homophobia or addressing racism. However, there's the study that is just underway, HIV prevention trials network, 096 building equity through advocacy. And it's really focused on Black MSM in the American South. And it's focused on the multi-level of intervention. And they're seeking really to incorporate intersectional stigma reduction and health equity into the model of care to see what impact that has on PrEP uptake and adherence, as well as HIV treatment, uptake and adherence. So, just to go in a little bit detail about the intersexual stigma reduction, that is an organizational level intervention that will take place in healthcare facilities that are that are part of the study. And it's really designed to optimize the health care environment for Black MSM by addressing their intersectional experience of racism, homophobia, transphobia, and HIV stigma. And they're seeking to do this through consciousness raising training for all staff. So really understanding, you know, how do these systems manifest in, you know, healthcare professionals in their practice? What role are they playing and working to dismantle these subsystems and really an opportunity for critical reflection. And then they're going to have a knowledge exchange where they've identified organizational champions who will really take a deeper dive into some of this critical reflection work really thinking about how do they improve their clinical practice to address these issues, they will discuss cases and think about what changes need to be made at an organizational level. And then there'll be a quality improvement collaborative, really exploring what

organizations need to do to ensure that prevention and treatment services are provided in an affirming and accessible way. And then some work with community stakeholders as well to develop sort of cross sectoral solutions. And so, this is the study again, underway will they'll have eight communities that are receiving this multi-level intervention, and then those who receive standard of care, and then we'll see so this will be an opportunity to understand in a sort of a rigorous research approach you know, what are potentially effective strategies for addressing racism, homophobia in the healthcare setting and the impact it has on communities who are impacted by HIV.

35:15

So next, what can be done at the organizational level? Again, so that was for patients that I was mentioning now, just in terms of what can be done for staff and leadership. So, creating spaces for learning and connection, and also considering incorporating racial equity tools into the work that your organization is doing. And so just to say, one-time trainings are really important but they're just sort of a stepping stone. This work requires time and investment is really a longitudinal process. So, one strategy that has been helpful that has been employed at the New York City Health Department, for instance, is really creating dedicated spaces for reflection and connection around undoing racism. And these are called affinity spaces and they have other names as well. And they basically describe people gathered with others who share a common element of their identity in order to explore and process their experiences around that identity and to collectively reflect on their lived realities. And so, these spaces can be an opportunity for white people who have a passion for ending racism, who may be angered, are confused about institutional racism, who have questions about race, that they may be fearful of asking in mixed company to really help to sort of process engage in meaningful conversations, and clarify their role in dismantling racism. And for people of color. These spaces can be places to work with peers, who experiences of racism, engage in healing work, create status strategies to advance racial equity within their organizations. And often as an accountability practice, these groups will come together really to share their learning process and what their insights. And so, another tool that can be used for racial equity tools, and in particular, when there is decision making happening, and this can be a simple decision, like what goes on an agenda all the way to like, you know, creating a budget and allocating funds. And so, by having racial equity tools, this can really help us to make equity an explicit part of any decision-making process. And so, the questions from this tool, which is called the racial justice prime, looks at, you know, who is benefiting from this decision? So, these are questions you would ask if you're at a sort of decision point, who was benefiting from this decision? How have we equitably included everyone's voice in the decision-making process? Who are we exploiting? How can we be more inclusive with this decision? How are we being explicit about our commitment to racial justice? And this decision we're making? How does this decision affect our black, indigenous and other people of color that we serve, as well as our bipod staff members? And what is the desired outcome of this decision? And how does this outcome connect to our commitment for racial justice? So even just reflecting on these questions, as decisions are coming up within your organization can help to ensure that you are explicitly considering equity in your decision.

38:40

So, what can be done at the community level? So, there are many things I'm just going to focus really briefly on Building Community Trust and Accountability? Often, we hear discussion about how marginalized communities are often mistrustful, again, which places the burden on these communities which pathologize them. And however, really, we want to sort of shift to thinking about how can institutions show themselves to be trustworthy? Or how do institutions build trust trustworthiness with the communities that they serve. Part of that is really developing accountability and partnership with impacted communities, black and Latino communities in particular. And so, this can look like being an organization or institution that intentionally identifies and builds two-way relationships with organizations and communities of color, and has them as key stakeholders in decisions. This can also look like an organization that practices community engagement in ways that allow voices, perspectives, and input from communities of color to drive, the organization's purpose and overall decision. This can also look like having policies and processes in place that allow organizational practices to be reviewed with community partners input and considered for change or elimination. It can also look like policies and practices that allow for responsiveness when community-based partners ask for our immediate support and action. It can also be evaluating and taking steps to address structural barriers that may be preventing patients or communities of color from engaging with services, whether this is related to funding to language access to documentation requirements that your organization might have. And then lastly, having accountable relationships with community partners, really allows them to be aware of and understand are the organizational decisions that are being made. So, these are just some ways that institutions need to begin to ask themselves, are we doing these things? Are we helping to build institutional trustworthiness in the communities that we serve. And this can help again, in shifting the burden from these communities, who have, you know, justified reason to be mistrustful to institutions, to focus on what they need to do to show themselves or to prove themselves trustworthy.

41:17
And lastly, what can be done at the policy level, and really, that's about really advocating for policies that reduce inequities. And I know many of you in the audience are probably already involved in organizing and add advocacy and activism at the policy level. And again, we'd love to hear about the work that you're doing during the q&a. This is by no means a comprehensive list, and I just selected two key issues, but just want to get a head nod to the importance of stable housing and employment opportunities for people placed at risk for HIV, as well as those living with HIV.

41:56
So, what about healthcare for all? You know, healthcare for all obviously, is the ideal and would definitely go, have a huge impact or go far away in reducing HIV related inequities. In the shorter term, we've seen many states expand Medicaid under the Affordable Care Act. And so, the map on the left shows the states that have adopted Medicaid expansion and those that have not, and the ones that have not adopted expansion are those in the dark blue, and we see that many of those are concentrated in the south, which is really the new epicenter for the HIV epidemic. And there are as many as 60,000 people living with HIV in states that haven't expanded Medicaid, which we know further exacerbates HIV disparities because black and Latino Americans living with HIV are more likely to rely on Medicaid for health insurance than

their white counterparts. There have been numerous studies that have looked at the effects of the ACA Medicaid expansion on a number of outcomes, and across a broad range of conditions. The Medicaid expansion has been shown to reduce health inequities, and in terms of HIV, the health benefits of Medicaid expansion. We've seen those among both people placed at risk for HIV as well as those living with HIV. Medicaid expansions associated with increases in HIV testing, diagnoses, greater uptake of PrEP, higher rates of continuous viral suppression, and improve quality of care and also declines in HIV incidence. And so, we know that New York State obviously expanded Medicaid under the Affordable Care Act, but really continuing to support efforts nationally, to push for health care for all is really important. And if we have connections and other states that have not adopted Medicaid, continuing to support our colleagues there as they push for a Medicaid expansion.

44:06
And then the other issue I wanted to talk about briefly is ending HIV criminalization. HIV criminalization, is really used to describe statutes that either criminalize otherwise illegal conduct, or that increase the penalties for illegal conduct that are based upon a person's HIV positive status. And we know that HIV criminalization contributes to HIV stigma. Again, I mentioned it's a form of anti-black structural homophobia when we look at who's most impacted by these laws. And almost all HIV criminal laws do not require transmission of HIV. And in most states, these laws criminalize behaviors that have like little to no risk of transmission such as spitting or biting. And most many states have also not updated their laws to align with existing sign hands around HIV such as undetectable equals on transmittable. And so, in this map, you can see there 35 states, the screen plus purple that criminalize behavior, either due to HIV or STI specific laws. And just to say that in New York State, while we don't have HIV specific statutes that criminalize HIV, we do have statutes that criminalize HIV and STI transmission. So, any person who knowingly, who knows that they have an STI and has sex with someone can be found guilty of a misdemeanor in the United in New York State. And that can be up to one year in prison or end and $1,000 Fine. And HIV is considered as we know and legally as well, an STI or quote unquote, venereal disease. And we also know that people with HIV have also been prosecuted under other general criminal laws and their HIV status has been brought into the case in ways that are harmful and stigmatizing. So, again, there's still work to do in terms of getting even the laws that criminalize STI, STI is off the books because we know that these again, contribute to HIV stigma, and as well as HIV related inequities.

46:24
And then lastly, in terms of the policy level, really centering racial equity and HIV related funding, and programming. Often funds do not go to grassroots organizations that are really on the front lines and uniquely positioned to engage with and support highly impacted communities, and especially organizations that are led by people who reflected are from the communities most impacted by HIV. And so, one example is this is that HRSA had the black woman's first HIV initiative, which you may have heard of, and out of $3.8 million that was allocated to fund projects. As part of this initiative, again, to support black and trans black trans and cisgender, women living with HIV, just 10% of the funding of the $4 million went to organizations that were led by black Cis or trans women, actually one of the programs doesn't even have a black woman in leadership in the organization in any way or as a PI. And so, these are lost

opportunities to support groups that have been doing this work for years and continue to do it often underfunded. And then we also need equitable provision of programming and services, as we currently have a mismatch in terms of who is being served and who is in greatest need. And this can be seen in this graph so that the middle bar reflects the status quo, and it's looking at the PrEP coverage among MSM, at high-risk for HIV. And you can see that about currently about 80% of PrEP users are white, 16%, black. And what they did in this study is they did a modeling study looking at two different approaches, looking at scaling of services, promotion proportional to the rate of new HIV diagnoses in a population, and then just scaling it up based on the status quo. And they found that both policy approaches increase the overall level of service delivery. So, we saw more people receiving an HIV test initiating PrEP starting treatment. But the key difference was that the equity approach, this approach on the on the right-hand side of the bar of the graph, that approach, increased services in a way that met the need and address the inequity in HIV diagnoses. And overall, the study found that an equity-based approach to HIV prevention and treatment services so when that's based on the distribution of HIV diagnoses, that that improve population health, it reduces costs, as well as HIV related inequities. So again, we must really encourage our funders to address this current mismatch. And identify strategies to ensure that funding for programs is going to where it is most needed.

49:23
I know, I presented you a lot of information, again, a potpourri of different strategies about that you can employ to become more structurally competent from the individual level, to the policy level. And we all have a role to play in really pushing for change so that we can really create a world in which everyone has the opportunity to thrive. And these are just a few pictures from my own advocacy work with my dad at a Stop and Frisk marched with colleagues from Montefiore. I'm really working towards health care for all. And then with my little one at the Women's March, and he's actually he has a moratorium on marches. So, that was his first and,

50:11
And last, I just like to end by saying how wonderful it is that nobody need wait a single moment before starting to improve the world. This is a quote by Anne Frank. But we all can do things big and small, to change to change the world and create a more equitable, and inclusive world for all of us. Thank you so much!

50:36
Thank you so much, Dr. Blackstock, for this really informative and wonderful presentation. I think the strategies that you shared also are really helpful and building off of some of the things that we discussed in the keynote. So, we really appreciate that. And just providing this ecological model with like a toolbox, almost of all different strategies that folks can use to intervene at different levels. So, we really appreciate that. A few questions are coming in.

51:05
The first question that I saw was earlier in your presentation, I think when you shared this sort of national level data, and someone asked if we had that for New York State, I can share that I know that some of that data might be on the ETA dashboard that we can also share. Not all of it

is broken down by the same aggregated data in terms of racial health disparities, and also gender or sexual orientation. Is there anything that would you recommend any sort of New York state resources?

51:39
So, I just want to make sure I understand was this from the graph that was showing like the time to end of the epidemic? Or was it this the general data that was from the CDC? But yes, I think you're completely right, like the ending the epidemic dashboard would be a great resource for folks who wanted to get more information and drill down a little bit more on state data. And then obviously, for the city just search, like surveillance, surveillance report in your city health department, and all of that data is online.

52:13
Great. Thank you. And we can also follow up with that. We have one question regarding some of the fund allocation that you mentioned. Someone asked what is happening to the funds that are supposed to be distributed for this end cause? Is there any accountability for misuse? And which organizations can we trust to donate to? And that's kind of a big question. I don't know if you want to comment on that.

52:34
When you say funds to what, um, so like, I think you're talking about the HRSA funds. Yeah. And how they weren't just they weren't distributed really in an equitable manner?

52:42
Yeah, well, I think it's really important, like for those of us who are in an advocacy group, who have a voice that we, you know, we push funders, CDC HRSA, to, you know, to live into their value that they're saying that they want to reduce health inequities, that they, you know, ensure that it's going to those organizations that really are positioned to do this work in a culturally in a structurally competent way. And so, I don't know if there are mechanisms, I know HRSA you know, there's sort of you know, they're planning council, planning councils for these different jurisdictions. But I don't know to what extent like the discussion around let's say, this HRSA, black women HIV initiative, whether that comes up in those spaces, but I know that there are definitely like, you know, advocates who are, you know, highlighting the importance of making sure that, you know, these funders, in the next iteration that they do a better job. But I think we can all again, hold these hold these funders accountable, to making sure that they're matching their funds with those communities that are in greatest need.

53:53
Absolutely. I also wonder if the process that you mentioned of self-accountability could also be helpful for organizations when they think about what funds you know, they apply for, and looking at their own internal leadership processes? I think, yeah, some of those strategies that you mentioned, are really helpful to organizations.

54:13

So, I have a question. Let's see, just to clarify, if a patient is undetectable and have sexual relations without disclosing HIV status, they can be persecuted or prosecuted.

54:23
So, again, I think a lot of these statutes are not, you know, they don't have that level of detail. And some of them are not up to date with the science. So, when I looked at the statute, where it says, quote, unquote, venereal disease, or you know, STIs, it doesn't specify again, it doesn't specify whether if someone has HIV, if they're on treatment, or someone has an STI that they're getting treated for and that they, you know, may pass it to on to a partner. So that's what that's the issue is that the, you know, the courts or lawyers can sort of us do what they can they can sort of morph and meld the laws to each specific case. So, we need like, again, like increased specificity around these statutes and they need to be updated with the science. So, that's like a really a great question. And that's something that is not incorporated into the law as far as, as my as I'm aware.

55:16
Absolutely. And what questions do other folks have from Dr. Blackstock? I'd also want to invite folks if they want to share, Dr. Blackstock mentioned, you know, are there any other strategies that folks find effective and trying to, you know, practice equity and structural competency in the work that they do. So, if anyone wants to have share questions, or also wants to share any effective strategies that worked for them. Someone did mention of course, we're all sort of still processing the Supreme Court decision. And also, kind of anticipating the domino effect, and especially how it will, it will really impact communities that experience multiple forms of marginalization and oppression. Someone asked if there's any political health care groups that I've read, that anyone wants to mention, in terms of getting involved in activism?

56:15
Yeah, I'm just going to quickly say, an Elsa meringue pub as YouTube, follow her on Twitter. So, she's just such a resource. And she her pin tweet, if that, you know, if you're if there's an injustice that you're wanting to take action on, like, she has, like a list of questions, and one is like, first look at what resources exist, that I can, you know, so that one can educate themselves better? Look around at who's already doing the work, like, you know, I think, those of us who may be despairing at the Supreme Court ruling, maybe folks who are like further away from the organizing the work that people have been doing for decades, people who predicted this, so think about who's doing the work? And are there ways that you can like, concretely support them, or help them either by providing funds or using your skills to support the movement and in a way that is constructive? So yeah, there are a number of, of healthcare organization, some of them are based on, like, I know, there's like for this like positions, but not conditions for reproductive justice. But I think what can be challenging is I noticed that a lot of these professional organizations tend to be very special, like if you're a physician, if you're a nurse, if you're a PA like, and the reality is that we work all together. And I think it is challenging to find healthcare, healthcare organizations that are inclusive of all members of the team. I'm part of an organization called New York docs. And even though it's called near docs, it's for all health professionals. And we do a lot of advocacy here in New York City, and as well as national advocacy. I would, so I would just consider like Googling seeing where you are, if there any

local groups that are doing work, and then there are a number of professional organizations, APHA, other groups that are that are pushing for meaningful change.

58:02
Absolutely, thank you. Let me see. I think we have time for maybe one more question. And it looks like it's a long question. Let me just, we'll see if we can touch upon it. Given that individuals vary in their desire to hear from their providers about structural factors, what do you recommend regarding inventory style assessments of possible structural barriers? Do you do a suggested framework or asking permission or gauging whether this type of assessment for a particular patient or a client?

58:32
Yeah, no, I think just incorporating it into, either when someone's waiting to be seen, or when you're with the provider, just sort of stating kind of, like what we do with the sexual history, like, these are questions that we asked, you know, of all of our patients so that we can, you know, provide, like the best care what so that we can know that you know, you know, what you're experiencing, what might be your needs or priorities, and that information will help me to take better care of you. I would just have it just like any, you know, just like any part of the history, that's something that might be challenging to ask about to really just normalize it. And, you know, just incorporate it and, you know, presented as a part of the sort of either intake or the history that you take from patients to ensure that, you know, you're providing them, you know, really tailored care that speaks to what they are experiencing in their lives.

59:28
That's a great point. So, I think that's all the time that we have for questions. Thank you so much, Dr. Blackstock for a fantastic presentation and for sharing all these strategies with us. We really appreciate you taking the time to present at our conference today.

59:43
Thank you, Jessica. And I just wanted to just really, I don't know I think I lost my cursor, but okay, just wanted to just share with providers. I'm also CDC ambassadors. So just and CEI is a wealth of information. There's and there's also the CDC Let's stop HIV together campaign that has a lot of content for both patients and clinicians. And then there's the HIV Nexus, which is also for clinical providers who are wanting just up to date information on evidence, guidelines and other resources. So just wanted to make sure I shared that.

1:00:17
Thank you for sharing. We will share the slides everyone will get these resources as well.

1:00:21
Okay, great. Thank you so much. Thank you.

[End Transcript]