IPG Meeting Notes

May 18, 2022, 1:00 - 4:00 p.m

Announcements

- In April, EOCIL launched a media campaign to promote HIV testing in eastern Oregon. The campaign includes billboards, social media, radio, and more. The campaign has generated lots of media attention, traffic to EndHIVOregon.org, and requests for condoms.
- May is Youth Sexual Health Awareness Month.

A syndemic approach to ending HIV

A syndemic approach to ending HIV is not limited to HIV or to sexual health. It involves looking at the whole person, including social and structural factors that affect their lives and their risk level (e.g., racism, income inequality, homophobia). To address these factors requires collaboration across various sectors and agencies.

Poll question: What does taking a syndemic approach to ending HIV in Oregon mean to you?

- Collaboration across sectors and silos (shared by 7 people)
- Working with people throughout our state
- Contextual
- Holistic, integrative
- Integration of HIV-negative partners
- Addressing upstream factors to ending the epidemic (e.g., institutional, structural, discrimination)
- Social determinants of health
- Interrelation of all areas
- Relationships
- Identifying disparities
- Understanding and supporting the whole person and not just a person with X "issue"
- Expanding social networks
- Wrap around services
- Coordinate with other systems of care
- Person in environment
- Integration of all areas
- Common sense
- Finding new partnerships

- Understand how the Social determinants of health (SDH) impact multiple health outcomes
- Comprehensive
- Making connections
- Big picture

Poll question: Using a syndemic mindset, what activities should we prioritize over the next 5 years?

- Supportive housing (shared by 5 people)
- Harm reduction and needle exchange (shared by 5 people)
- Home testing (shared by 2 people)
- Team building and partnerships
- Social determinants of health
- Prevention home testing rapid ART
- STI home testing
- HCV treatment
- Peers across state
- Efforts to support equitable access for BIPOC folx
- Sexual education in schools
- Ending inequities with a focus on housing & criminal justice
- MAT
- Increase staffing of staff along the continuum of care
- Prevention and support services/activities for key at risk communities
- Facilitating access to treatment and PrEP in rural areas
- Home testing
- Working with people who use substances and overlapping viral hep c efforts with hiv
- Transportation, other SDOH
- Testing everyone
- SUD treatment
- Rapid ART
- Integration of HIV-negative survivors
- Telehealth
- Partnerships with substance use treatment/prevention,
- Rural focus

Promoting Sexual Health among Adolescents & Young Adults

OHA's Youth Sexual Health/School Health Lead shared an overview of activities to promote youth sexual health in Oregon.

In the past:

- Youth sexuality education has been controversial.
- The Oregon Youth Sexual Health Plan has guided statewide efforts. Its goals include youth using accurate information and well-developed skills to make thoughtful choices about relationships and sexual health; reducing unintended pregnancy, STIs, non-consensual sexual behaviors; and eliminating sexual health inequities.

Today:

- Oregon is seeking youth leaders (15-19) to serve on an OHA youth advisory council for COVID school recovery. Members will receive $45 per hour.
- Youth are demanding sexual health education that is inclusive of trans youth. They're asking to be heard, and they're asking for safe spaces.
- In 2020, youth developed an LGBTQ2SIA+ Student Success Plan. The Oregon Department of Education has a position focused on supporting this plan and other plans. There is also funding to support local implementation of the plan.
- In Oregon, sexuality education starts in kindergarten, with a focus on understanding healthy relationships.
- OHA's Youth Sexual Health Program supports sexuality education for youth in transition programs with intellectual and developmental disabilities. Funding goes to OHSU's University Center for Excellence in Developmental Disabilities (UCEDD) in collaboration with the Oregon Department of Education. The curriculum used is called Friendships and Dating.

Discussion:

- Q: At what age can youth consent to STI testing?
    - A: Participants shared a range of answers. This OHA fact sheet addresses minor rights and access and consent to health care in Oregon. The fact sheet states that "every day, health care providers are attempting to figure out: (1) which services a minor can obtain without parental consent; (2) when a parent can access a minor's health information; and (3) when minor consent must be obtained before the provider can share the minor's health information. State statutes, federal laws and regulations provide a complicated patchwork of requirements that often do not fit neatly together and may be challenging to interpret and implement."
- Q: How do we create safe providers for youth of all sexual orientations and gender identities?

    - A: This is a policy issue, plus a “hearts and minds” issue. There’s lots to do. Could youth receive gender-affirming care through school-based health centers? Also, let’s remember that young people are affected by HIV too.
    - A: The National HIV/AIDS Strategy includes a call for LGBTQ-inclusive policies.
    - A: It’s important that youth feel empowered to ask for the services they need, such as STI testing.
    - A: Youth need education about the age of consent for services, such as STI testing, plus information about insurance coverage and billing.
- Some school based health centers are hesitant to discuss PrEP because of a belief that kids won’t take medicine. How can we challenge those assumptions?
- OHP pays for PrEP, and this should be more widely known and used!
- PrEP is important to people who choose to have condomless sex.
- Many parents are uncomfortable discussing sexual health with their children.
- PrEP is also an option for people who may not have the privilege of choice.
- Q: Can we engage/collaborate with the Youth Advisory Council?
    - A: Yes, this is possible!

Draft HST statement on using race/ethnicity data

OHA HIV/STD/TB Section (HST) staff asked for feedback on a draft statement about the section’s use of race/ethnicity data. HST is intentionally leading with race and ethnicity in its approach to achieving health equity. This statement was developed to be used alongside race/ethnicity data with the intent of contextualizing the data, owning that data on race and ethnicity are far from perfect. HST’s larger health equity statement can be found here.

Option 1

The measurement of race and ethnicity in public health data, including data on HIV, STI, and TB, is flawed. Race is a social not a biological construct. Thus, using race to organize and understand human biological variation is false and harmful as it only serves to pathologize Black, Indigenous, and non-Black people of color (BIPOC) and Tribal communities. Race, instead, reflects the complex interactions of engineered, racist economic, political, and social policies, systems, and structures that lead to inequities in HIV, STI, and TB in Oregon. As public health practitioners work to find ways to collect information that more precisely reflects the health effects of systemic racism, the presentation of HIV, STI, and TB data by race and ethnicity is intended to call attention to the current, ongoing effects of centuries of racism, discrimination, and oppression on health. The racial and ethnic inequities in HIV, STI, and TB among BIPOC and Tribal communities deserve immediate, authentic, reparative action. The HIV/STD/TB Section of the Oregon Health Authority commits to working with community partners to improve data collection, interpretation, and sharing and, ultimately, eliminate inequities in HIV, STI, and TB.

Option 2

The HIV/STD/TB Section of Oregon Health Authority recognizes that race is a social construct and that using racial categories to organize and understand variation can be misleading and harmful, often serving to pathologize and blame Black, Indigenous, and non-Black people of color (BIPOC) and Tribal communities. Moreover, we acknowledge that health equity can only be achieved when public health measurements of “race” do a better job at capturing the complex systems of economic, political, and social inequities that lead to ongoing disparities in health. As we continue our work to eliminate inequities in HIV, STIs, and TB in Oregon, we are committed to working with community partners to improve the ways in which we collect, interpret, and share our data.

Option 3

The HIV/STD/TB (HST) Section of the Oregon Health Authority (OHA) recognizes that race serves as a proxy for lived experience of racism. Collecting race and ethnicity data is necessary to end health inequities, but these data can be misinterpreted or used to blame or pathologize individuals and their behaviors. Race, Ethnicity, Language, and Disability (REALD) standards were legislated in Oregon to support data justice in communities most affected by health disparities. As we continue to work to eliminate inequities in HIV, STIs, and TB in Oregon, HST is committed to working with community partners to improve the ways in which we collect, interpret, share, and make our data more context-specific and actionable.

Preferences:

- Eight people who liked Option 3 best
- Six people liked Option 2 best
- Two people liked Option 1 best

Discussion:

- I like the sentence in #1 that ends "deserve immediate, authentic, reparative action" (2 people)
- I like the BIPOC term mentioned in all three options.
- Some people are not fond of the “BIPOC” acronym.
- It’s important to spell out BIPOC.
- I am from the BIPOC community. It's okay but has to be shown with context. Not just thrown out of the blue.
- BIPOC was created to acknowledge the specificity of anti-Blackness and anti-Indigenous oppression and how within communities of color, our experiences are not the same. It has a specific use. I would invite OHA to consider when it makes the most sense to use i.e. not using BIPOC if a data set or program has no Black people represented.
- I also like spelling out the populations you are talking about rather than rely on BIPOC

- I wonder if continuing to use "flawed data or constructs" is harmful and maybe consider discontinuing use until it is "fixed" to be more accurate and relevant and not potentially harmful?
- I would like to see a commitment to action added to the statement (comment voiced by two participants)
- These are hard statements to write and I acknowledge your intention that these are difficult measurements. When I see the first word in option 1 of flawed, I automatically discount the rest of the paragraph.
- I think calling out how disaggregated data also impacts communities of color and naming exactly how OHA is committed would be helpful
- As an Indian American, I find it demeaning as I feel cultural sensitivity is still lacking in government. Have a zest for learning cultures!
- I do like linking to REALD and SOGI data collection as a state investment and a commitment to use data to make systems change for historically marginalized communities. (comment voiced by three participants)
    - Keep in mind intersectionality and SOGI as it relates to REALD in the statement.
    - I feel that REALD is a good approach because it encompasses more than race. There are many underserved communities in our state, Ethnicity and culture is one facet of the rainbow of mankind. We have to accept that some people do belong to multiple underserved communities. I belong to three but not everyone is used to that. They expect someone to belong to only one underserved community. Diversity is accepting that a person is not limited to people's preconceived notion of our world.
- I like line one of Option 2. Maybe add that to option 3?
- Q: Can we take our favorite lines for all three to make a new statement?
    - A: Please email suggestions to Amy.
- Q: When will HST finalize the equity statement?
    - A: While there is not a deadline, HST would like to collect feedback within a month.

Ongoing impact of COVID-19 on HIV/STI testing and diagnosis in Oregon, 2020-2021

Testing

Rates of testing for HIV, Gonorrhea, and Syphilis (in both the public and private sectors) are lower during the COVID era (3/2020-12/2021) compared to the pre-COVID era (1/2019 - 2/2020). This is true for both public and private sector testing. Testing rates are recovering over time, though we have not seen a full recovery just yet.

HIV testing increased in the vaccine period, then decreased in the Delta/Omicron period.

Diagnosis

While HIV and Gonorrhea diagnoses declined during the COVID era, primary and secondary syphilis diagnoses increased during the COVID era.

Discussion:

- Q: Are there hot spots for Syphilis in Oregon?
    - A: Yes. Generally speaking, the Portland metro area and the I-5 corridor is where cases are concentrated. Umatilla and Malheur counties have cases too.
    - A member noted that Umatilla and Malheur counties both have prisons.
- Q: To what do you attribute the rise in syphilis diagnoses (while other STI diagnoses declined)?
    - A: Chlamydia is often asymptomatic and identified through routine screening. Routine screenings were less common during COVID. Gonorrhea and syphilis tend to be symptomatic and may prompt a visit to and diagnosis by a health care provider. In addition, syphilis cases were likely impacted by amplified social determinants of health during COVID (e.g., increased houselessness, unemployment, substance use).
- Q: Were the decreases in HIV and Chlamydia cases an artifact of less testing?
    - Yes, declines in routine screening are likely a major reason for the declines.
- Q: What's the incubation period for syphilis?
    - A: People can generally transmit syphilis once they show symptoms. However, symptoms are not always external (e.g., in the mouth) and can go unnoticed.
- Q: Can we expect more cases when there's a decline in routine testing?
    - A: Yes. When routine testing declines, more people are likely to remain undiagnosed for longer. People with undiagnosed infection are more likely to unknowingly transmit HIV.
- Q: Can we expect cases to continue to increase?
    - A: It's important for us to expand access to HIV and STI screening. Home-based testing services (such as https://takemehome.org/) may be particularly important when access to or use of clinic-based services is limited.

OHA plans to:

- Continue working with the Communications Department to help raise awareness of syphilis;
- Release a request for proposals for syphilis education for both the public and for providers; and
- Releasing broader screening recommendations for syphilis.

Congenital Syphilis in Oregon, 2014-2020

In the US, congenital syphilis cases have been increasing since 2013 (among people assigned female at birth, ages 15-44). These cases can result in stillbirth and neonatal death.

In 2019, Oregon ranked #11 for congenital syphilis cases. Statewide, early syphilis has increased by more than 1300% among people assigned female at birth since 2013. From 2014-2020, there were 248 cases of syphilis in pregnancy; 69 (28%) of those cases resulted in congenital syphilis. One reason for the increase in cases among heterosexual people assigned female at birth is that more members of this population with early syphilis are reporting injection drug use. The majority of cases (about 80%) are in the Portland metro area.

Addressing syphilis is an issue of racial justice. The disparities by race and ethnicity are not due to differences in individual risk behaviors, but to social determinants of health such as houselessness and incarceration.

Oregon's recommendations for syphilis screening among pregnant people include:

- Screen at first presentation to care
- Screen again at 24-28 weeks (early third trimester)
- Screen at delivery
- Any pregnant person with a delta demise after 20 weeks

Congenital syphilis is preventable. The challenge is to get folks 1) in prenatal care, 2) screened, and 3) treated if they test positive. We also need to improve coordination with health systems and housing services. Delayed care and diagnosis are more likely for folks with unstable housing and substance use.

OHA is continuing to implement various efforts to raise awareness of syphilis, both among providers and the public.

Discussion:

- The Oregon AETC offers one-on-one detailing with providers to help them align their practice with Oregon's guidance related to congenital syphilis. Providers can schedule check-ins directly with Dr. Chris Evans on the Oregon AETC website.
- Q: Can we expect cases to continue to rise in the Portland metro area, given the large population of people experiencing houselessness?
    - A: Sweeps of camps have the potential to impact transmission—changing social and sexual networks. We need decision makers to understand how houselessness, incarceration, and public health are all interconnected.
    - Comment: Basic needs, mental health care, addiction care, food, housing, are public health and need to be treated as such. These are drivers of

houselessness along with not enough low-barrier housing. OHCS is doing amazing comprehensive work! There is hope!
    - Comment: Survival sex is a real phenomenon, and women are traditionally on the lower end of the social ladder in marginalized groups. I.E. women will inject 'after' the male in a sex/drug network scenario.
    - Portland Street Medicine is one of OHA's new CBO grantees, which will be working with people experiencing houselessness to receive comprehensive medical care, including HIV, STI, VH screening & treatment.
- Maybe there should be mobile vans for prenatal care like there are for dental mobile vans.
- Q: Could we do a mass mailing or outreach to help raise awareness?
    - A: That's a great suggestion. We're not limited to social media.
- Q: How long from time of exposure until a positive result for syphilis?
    - A: About 6-12 weeks.
- Q: How long from Primary to Tertiary syphilis?
    - A: This can take decades.
- What about t-shirts saying, "Ask me About The Latest News about STIs in Oregon?" Also targeting Peer navigation services such as Project Nurture at Providence would be a great option (Prenatal) care for women with OUD. I am also thinking about public service messaging to recovery houses, MAT, women's groups.
- Education is important. Many clients don't understand syphilis is still here and it has serious impacts.
- New Zealand has a campaign called "Syphilis is back from the Dark Ages," acknowledging and challenging the common belief that it's gone.
- Can we make 3rd trimester testing mandatory?
    - Some states have done this. It's something to consider as we continue to monitor trends.
- Many people don't know the symptoms of syphilis. More education is needed.
- Are there different means for STI testing, and if so what are they?
    - Blood samples are needed for syphilis, hepatitis B and C, and HIV testing. A urine sample or vaginal, rectal, or pharyngeal swab can be used to test for Gonorrhea. We may soon have new ways to test for HPV.
    - There is a vaccine for HPV too. It's terribly under-utilized however. Parents do not want to think of their kids having sex, instead of seeing it as a cancer-prevention strategy!

Feedback

- I like the polls and presentations.
- I miss in-person, all-day meetings. (x2)
- I had problems using the QR code.
- Breakout rooms are fun.
- One additional break would be nice.
- A couple people like the idea of starting 5 minutes after the hour.
- Opportunities to interact are appreciated.
- We do an amazing job!
- Share the presentation slides after the meeting.