

CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

of the

COMMITTEES ON HEALTH AND YOUTH SERVICES

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September 23, 2009

Start: 1:00pm

Recess: 3:10pm

HELD AT: Council Chambers
City Hall

B E F O R E:
JOEL RIVERA
Chairperson

COUNCIL MEMBERS:
Inez Dickens
Mathieu Eugene
Lewis A. Fidler
Helen D. Foster
Sara M. Gonzalez
John C. Liu
Rose Mendez
Kenneth C. Mitchell
Helen Sears
Kendall Stewart
Eric A. Ulrich
Albert Vann

A P P E A R A N C E S (CONTINUED)

Dr. Monica Sweeney
Assistant Commissioner of the Bureau of HIV Prevention
and Control
New York City Department of Health and Mental Hygiene

Dr. Harold Hamilton
Speaker on behalf of Dr. Jeffrey Birnbaum
Director
Health Education and Alternatives Program for Teens
SUNY Downstate Medical Center

Jose Davila
Executive Director
Bronx AIDS Services

Lyndel Urbano
Manager of Government Relations
Gay Men's Health Crisis

Calvin Lavelle
Member
Health and Education Alternatives for Teens

Jaron Megolanez
Program Manager of LGBT Services
Asian and Pacific Islander Coalition on HIV and AIDS

Jacobi Johnson
Program Director
Black Men's Initiative, Harlem United

Craig Cobb
Acting Executive Director
National AIDS Education and Services for Minorities

Steven Gordon
Direct of HIV Services
Ali Forney Center

[pause, background noise, gavel]

CHAIRPERSON RIVERA: Good

afternoon, ladies and gentlemen, my name is Joel Rivera, I'm the Chair of the City Council's Health Committee. Today, the Committees on Health and Youth Services are conducting a joint hearing on the HIV and AIDS among young men, ages 13 to 17, who have sex with men. I would like to thank my co-chair, Council Member Lew Fidler, for joining me and holding this important hearing, and for all of his leadership in bringing the homeless runaway and disconnected youth issues to the forefront where it belongs. Many of you know that the Health Committee previously held a hearing on the rise of HIV and AIDS among young men of color who have sex with men. Since HIV and AIDS epidemic began in the United States in the 1980s, it has primarily affected men, particularly men who have sex with men, and men of color. Nationally, and in the City of New York, men represent three-quarters of the HIV and AIDS diagnosis, while most populations are enjoying decreases in HIV and AIDS incidents and diagnosis, while the proliferation of the virus in young men who have sex with men

continues to rise. There are many challenges in reaching young men between the ages of 13 and 17. Several factors may contribute to the prevalence of HIV and AIDS in this special population, including earlier start of sexual intercourse, not knowing one's HIV status, inability to reach young men who have sex with men with effective educational interventions, underestimation of the risk of HIV due to advances in medicine, stigma and cultural issues, homelessness and disconnection and alcohol and substance abuse. At our last hearing, we heard firsthand about the issues that most affect them. Some of the gentlemen discussed depression and feelings of worthlessness, that can lead one down a path of self-destruction. Yet a particular young man described how he enrolled in physical and mental health services and was able to get his life back on track. It is this type of example that must spur action. Clearly we must work to overcome these challenges and link these vulnerable individuals with the care they need. While this population may be hard to identify and bring into the healthcare system, the Department of Health

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2 and Mental Hygiene and the provider and advocacy
3 community can reach these individuals through
4 innovative and targeted intervention. Today we
5 will hear from the Department about their
6 initiatives and strategy to combat HIV and AIDS
7 among this population, and from the provider
8 community about the services that they believe are
9 most valuable. I'd like to thank the staff of the
10 Committee for their hard work and before I
11 introduce my colleague, will introduce the members
12 who are here with us today. We have Council
13 Member Helen Sears and Council Member Sara
14 Gonzalez. Council Member Lew Fidler.

15 CHAIRPERSON FIDLER: Thank you,
16 Chairman Rivera, and I also want to thank you and
17 the Health Committee and the staff of both
18 committees for putting this hearing together this
19 afternoon, and welcome to everybody. In the time
20 I've been Chairman of the Youth Services
21 Committee, there have been, there really has been
22 no issue that I've devoted more time and attention
23 to than the plight of runaway and homeless youth.
24 I believe we've conducted approximately 13
25 hearings on this topic, and today's joint hearing

1
2 is a logical extension of, and supplement, to the
3 work that the Committee's been doing. For those
4 who don't know, it is important to understand and
5 appreciate that young people in New York City find
6 themselves homeless for a host of reasons. Many
7 homeless youth in New York City have run away from
8 homes where they may have been subjected to abuse
9 or sexual exploitation, exposed to domestic
10 violence, or had substance abusing parents. Some
11 are rejected at home because of sexual
12 orientation, pregnancy, problems at school, or
13 issues with drugs and alcohol. 43 percent of
14 runaway and homeless youth, both boys and girls,
15 report experiencing physical or sexual abuse prior
16 to leaving home. Among girls alone, the number
17 reporting physical and sexual abuse increases to
18 an amazing 80 percent. Youth leaving detention
19 placements for those aging out of foster care are
20 also at increased risk of finding themselves
21 homeless. Studies have shown that young people
22 who are out of foster care struggle to become
23 self-sufficient, and more than one in four young
24 people leaving foster care become homeless and
25 enter the shelter system. The Empire State

Coalition estimates that there are approximately 3,800 young people who are homeless each night in New York City. Think about that number for a second: 3,800 young people homeless each night in New York City. Of those young people, approximately, 150 are spending the night with or as a sex work client. These may even be conservative estimates. The prevalence of sexual exploitation amongst runaway and homeless youth is overwhelming. After an average of only 36 to 48 hours of being homeless on the streets, a young person is likely to be solicited for sex in exchange for money, food or shelter. Many homeless youth engage in survival sex, selling sexual acts to meet basic or substance needs, subsistence needs. One study found that 61 percent of male youth living on the street had engaged in survival sex. Youth with a history of abuse by family members were twice as likely to report engaging in survival sex. It is estimated that commercial sexual exploitation affects nearly 4,000 youth in New York City. Although I understand that men who have sex with men include many persons who are neither runaway nor homeless, I felt compelled to

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2 share with you just some of the extreme plight
3 that is born by this distinct population. Since
4 the heroic men and women who work primarily with
5 runaway and homeless youth in our City recently
6 reported to me that there appears to be a rise in
7 reported cases of HIV/AIDS among our runaway and
8 homeless youth population, this hearing is
9 particular timely. At this time, I'd like to hear
10 from those who came to testify today, specifically
11 as to the HIV/AIDS issues affecting young men who
12 have sex with men, and to learn of the efforts
13 being made by the City to help protect these young
14 people. Chairman Rivera.

15 CHAIRPERSON RIVERA: Thank you very
16 much for your comments. Let's first have Dr.
17 Monica Sweeney from the Department of Health and
18 Mental Hygiene. Dr. Sweeney, just press the
19 button, to confirm it's on, state your name and
20 title, and you may proceed with your testimony.
21 You need some water? [pause]

22 MONICA SWEENEY: Good afternoon,
23 Chairman Rivera and Chairman Fidler, and members
24 of the Health and Youth Services Committees. I'm
25 Dr. Monica Sweeney, the Assistant Commissioner of

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2 the Bureau of HIV Prevention and Control for the
3 New York City Department of Health and Mental
4 Hygiene. I would like to thank you for the
5 opportunity to discuss HIV/AIDS among young men
6 who have sex with men, or MSM, in New York city.
7 Today I will identify and assess the prevalence of
8 disease among this demographic group, describe
9 Department of Health programs and initiatives, and
10 identify some of the key challenges that we face
11 in addressing this problem. Public health
12 measures have been effective in slowing the
13 overall transmission of HIV and AIDS in New York
14 City, with the number of new diagnoses each year
15 falling by nearly one-third between 2001 and 2007.
16 A decline has also occurred from many demographic
17 groups. But it's most notable among injection
18 drug users who experienced a 72 percent decrease
19 in new diagnoses from 2001 to 2007. The risk of
20 acquiring HIV perinatally has also decreased
21 dramatically. Of the 441 HIV exposed births in
22 2007, just seven infants have thus far been
23 reported as having been born with HIV. The number
24 of children in New York City diagnosed with HIV
25 infection before age 13, fell from a high of 359

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2 in 1992 to just ten in 2007, the last year for
3 which we have complete data. And among all men
4 who report having sex with men, the number of HIV
5 non-AIDS diagnoses have declined by 2.1 percent
6 between 2001 and 2007. Despite this progress, and
7 as I noted in my testimony to the Council in May
8 2008, recent data has shown that some specific
9 demographic groups are infected at
10 disproportionate rates. While most MSM reported
11 to the Health Department with newly recognized HIV
12 infections are over age 30, the number of HIV
13 diseases among, diagnoses among MSM under age 30,
14 is increasing. The group had 420 HIV diagnoses in
15 2001, as compared to 592 diagnoses in 2008, based
16 on preliminary data for that full year. Among the
17 youngest category, age 13 to 19, new diagnoses
18 increased from 50 persons diagnosed in 2001, to 99
19 persons in 2007, before dropping to 80 in 2008.
20 In 2007, MSM aged 13 to 19 accounted for less than
21 ten percent of all new diagnoses among MSM in New
22 York City. And new HIV non-AIDS diagnoses are
23 occurring in the older segments of the cohort.
24 That is age 15 to 19, rather than age 13 and 14.
25 The prevention of HIV is central to the Health

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2 Departments overall plan to improve the health of
3 New York City, of all New Yorkers. So Take Care
4 New York 2012, a health policy agenda for the
5 city, that prioritizes specific action steps to
6 improve health, includes stopping the spread of
7 HIV and other sexually transmitted diseases, as
8 one of our top ten health priorities. Our
9 prevention strategy focuses on encouraging young
10 people of any sexual orientation to delay the
11 initiation of sex, and for those who are sexually
12 active, to reduce the frequency of sexual
13 encounters, and use condoms consistently. We are
14 reaching teens in every way we know how, including
15 education and school about risk of sex, internet
16 site messages, HIV and STD testing in various
17 settings, and providing condoms for those who are
18 sexually active. In our schools, our partners in
19 the Bureau of STD are working hard to educate
20 adolescents about sexually transmitted infections,
21 or STIs, including HIV, and to voluntarily screen
22 them for Chlamydia and gonorrhea, since we know
23 that having Chlamydia places a sexually active
24 person at greater risk for HIV. During the
25 2008/2009 academic year, the Health Department's

1
2 step up program educated over 24,000 high school
3 students about STIs, including HIV, and tested
4 11,410 students. Fully 111 high schools located
5 at 28 campuses in all five boroughs participated
6 in this program. Nearly half of all high school
7 students that were offered screening accepted the
8 offer. Over the past year, the Health Department
9 has held a series of focus groups to better
10 understand the ways in which HIV prevention
11 messaging did or did not resonate with the
12 population of interest. We have learned through
13 these focus groups that many young MSMs see very
14 few messages that encourage them to adopt safer
15 sexual behaviors. Research has also shown that
16 the vast majority of MSM in New York get their HIV
17 prevention information from the internet. In the
18 past 12 months, the Department has developed New
19 York Teen MySpace, an interactive portal on mental
20 health for teens, which to date has had more than
21 70 page views, and 1,118 MySpace friends. We have
22 also started collaborating with new and
23 nontraditional partners around new media to reach
24 young MSM. These new partners include the Global
25 Business Coalition to fight HIV/TB/Malaria; the

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2 Kaiser Family Foundation, part of CDC's Black AIDS
3 Media Partnership; and the National Act Against
4 AIDS Campaign; BET and Hip Hop for Life, a
5 nonprofit organization based in New York City,
6 focusing on empowerment for at risk teens, age 12
7 to 18. DOH considers HIV testing an effective
8 form of HIV prevention, as people who find out
9 they are HIV positive reduce their risky behaviors
10 by approximately 50 percent. The earlier people
11 learn their status, the earlier they're able to
12 benefit from lifesaving treatment and reduce their
13 viral loads, making them less infectious to
14 others. Our nine Health Department STD clinics
15 tested 5,804 adolescents, age 13 to 17, from 2008
16 to mid-2009, and through this testing identified
17 16 positive individuals. The number of visits
18 made by 14 to 19 year olds to our STD clinics rose
19 by eleven percent, from 2007 to 2008's school
20 year. Sites funded by our Bureau to conduct HIV
21 screening tested another 12,925 New Yorkers, age
22 13 to 19, identifying 44 persons with a positive
23 test result. Another program of note is the New
24 York City's school based health center program
25 that is overseen by the New York State Department

of Health, and managed locally by the Health Department's Office of School Health. There are currently 42 school based health centers serving high school students, operated by article 28 certified medical facilities, such as Lutheran Family Health Center network, North Shore Long Island Jewish Health System, Montefiore Medical Center, and William F. Ryan Health Center. One such clinic conducted 202 pretest counseling visits and 182 HIV testing visits between January and June of this year. As part of our strategy to encourage safer sex for those who are already sexually active, our Bureau also works closely with the Office of School Health, a joint program between the Department of Education and the Department of Health, to support condom availability in high schools. The social vulnerability of adolescent MSM places them at great risk for separation from family, unstable housing, substance use, and other unsafe behaviors. In order to address these issues in a comprehensive fashion, Health Department staff participate on the executive committee of the Connect to Protect Coalition, and as members of

1
2 the New York City Association of Homeless and
3 street involved youth organizations. These
4 networks bring together government agencies,
5 community based organizations and interest groups
6 serving young MSM and other vulnerable youth
7 throughout the City. Their goal is to provide a
8 more comprehensive service landscape for the
9 diverse population, which is at risk for HIV
10 infection. Further, all twelve agencies funded by
11 our Bureau to screen for some of the key comorbid
12 conditions that increase risk for HIV
13 transmission, including sexually transmitted
14 infections, substance use and depression, screen
15 MSM along with other high risk populations. All
16 four of these agencies, more than ten percent of
17 the projected annual population served, is
18 individuals aged 13 to 17. Though teenage MSM
19 represents a small portion of HIV infection in New
20 York City, it is a growing problem with which we
21 are concerned. Despite the efforts I have
22 reviewed, many challenges remain in addressing HIV
23 among young MSM in New York City. As a society
24 and community, we must address the new and
25 potentially dangerous norms that have resulted

1 from the success of antiretroviral treatment.
2
3 There is a need for a better understanding of the
4 ways the internet affects risk taking behaviors,
5 and to evaluate the impact of broad range of
6 prevention strategies and programs currently
7 employed in New York City and in other major
8 jurisdictions. Controlling the spread of HIV
9 requires a coordinated effort at the federal,
10 state and local level. Unfortunately, today's
11 fiscal climate is further constraining an already
12 limited pool of available public health funding.
13 With this in mind, it is our collective
14 responsibility to direct resources as efficiently
15 and effectively as possible, to control this
16 epidemic. Thank you, and I am happy to answer any
17 questions you may have at this time.

18 CHAIRPERSON RIVERA: Thank you very
19 much, Dr. Sweeney. Before we go ahead and ask
20 questions, I just want to introduce the colleagues
21 who joined us. We have Council Member Mathieu
22 Eugene, to my right; we have Council Member
23 Kendall Stewart, to my left; Council Member Eric
24 Ulrich, as well; and Council Members Inez Dickens
25 and Helen Diane Foster. And Rosie Mendez and Al

1 Vann was in the room earlier as well. Dr.
2 Sweeney, just wanted to, you know, touch base. I
3 want to thank you for your testimony, 'cause we
4 have had hearings on this in the past, and we do
5 want to monitor this situation. You mentioned in
6 the last part of your testimony the fact that, you
7 know, there has to be a joint effort between city,
8 state and federal governments, to tackle this
9 issue. What is the overall budget that the City
10 of New York spends on this targeted community?
11 And how much of that comes from state and federal
12 dollars?
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14 MONICA SWEENEY: Since many of the
15 programs that are funded to address this target
16 population is not isolated in an organization, so
17 when we give an organization funding, part of it
18 is targeted to the organization, but overall the
19 organization spends that money on many other
20 vulnerable populations. To isolate that number
21 exactly is very difficult.

22 CHAIRPERSON RIVERA: Okay. Is
23 there any one organization that specializes within
24 this target demographic in the City of New York,
25 that really does, you know, deal with the issue of

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2 youth having, young men having sex with men from
3 13 to 17? Or is it like you just stated, you
4 know, large organizations that deal with multiple
5 demographics and that may have division of deals?

6 MONICA SWEENEY: My understanding
7 is that Hetrick-Martin does deal with adolescents
8 exclusively. That's my understanding.

9 CHAIRPERSON RIVERA: And Hetrick-
10 Martin, do they, are they a citywide organization,
11 and how, what is their total number of youth do
12 they see on a, on a yearly basis.

13 MONICA SWEENEY: They have,
14 Hetrick-Martin Institute has, is located in New
15 York City and they have MSM programs, but I
16 couldn't tell you what their budget is.
17 Organizations get a little touchy when you start
18 asking them how much money they have for various
19 things, because what they come to us for is
20 funding. And when you start asking them what
21 other funding do you have, they're not always so
22 happy to share that information.

23 CHAIRPERSON RIVERA: Okay.

24 MONICA SWEENEY: I just want to
25 clarify one other thing. I understand that I

2 said, when I was talking about the teen MySpace,
3 they had 70, 70 page views, it's 70,000, that
4 teenage MySpace that I was talking about, in terms
5 of dealing with teenagers and their depression and
6 so forth. It's 70,000 hits.

7 CHAIRPERSON RIVERA: So 70,000 hits
8 to MySpace page.

9 MONICA SWEENEY: The MySpace, yes.

10 CHAIRPERSON RIVERA: And you
11 obviously have other pages as well, like FaceBook
12 and--

13 MONICA SWEENEY: Yes, we do. Yes,
14 we do.

15 CHAIRPERSON RIVERA: You know,
16 Twitter and other online vehicles, as well.

17 MONICA SWEENEY: We're not doing
18 Twitter yet, but we are doing several others,
19 including FaceBook. We have inSPOT as a way that
20 people can notify their partners that were
21 exposed. They can either do it anonymously or
22 divulge their identity to let their partners know
23 that they should go and get tested. It's another
24 electronic means of reaching people who otherwise
25 may not notify their partners.

2 CHAIRPERSON RIVERA: Okay. Now
3 back to the, to my original questions. Do we know
4 exactly where the highest populations of this
5 demographic is being affected? Is it, you know,
6 certain areas in The Bronx, Brooklyn, Queens? D
7 owe have that demographical information broken
8 down?

9 MONICA SWEENEY: I have the last
10 year for which we have data, which is most of the
11 MSM in New York City of any age group, are in
12 Manhattan. More MSM are in Manhattan than any
13 other age group. 95 percent of the MSM, thank
14 you, 95 percent of the MSMS in this age group are
15 of color, they are Latinos or black. And, but to
16 say where they either get infected or where
17 exactly they get care. But we can provide the
18 location to you of the 80 newly diagnosed after
19 the hearing, that was for 2008. The 80 that were
20 diagnosed in 2008, we can provide you the
21 locations of where they came from.

22 CHAIRPERSON RIVERA: Okay, that'll
23 be helpful, I mean, you know, it would make, you
24 know, and it would make sense that if we could
25 identify where the youth live, where they

1
2 congregate, where they're most susceptible to
3 getting infected, to really have targeted
4 organizations that can deal, you know, with this
5 demographic. I mean, you know, if, I really
6 appreciate the fact we have a great organization
7 in Manhattan that deals with it, but we also have
8 a population maybe in Brooklyn or maybe in The
9 Bronx or Queens, or in Staten Island, it may be
10 difficult for them to seek services in a
11 centralized location like Manhattan. So maybe, I
12 don't know if, in the Department of Health
13 offices, in the outer boroughs, maybe there's an
14 opportunity to do something there, or in
15 conjunction with the schools, since you do have a
16 school based program that currently exists to
17 reach out and identify where the areas of highest
18 risk and concern could potentially be, and then we
19 can work, you know, with the agency and the
20 Council and the Mayor's Office to try to target
21 resources and funding to, you know, to target that
22 specific community and that, in that location.
23 Because, again it may be difficult for someone to
24 seek, you know, services outside of where, outside
25 of their home borough, so--

2 MONICA SWEENEY: I do want to point
3 out that in all five boroughs, there are resources
4 for men who have sex with men, however, they
5 identify themselves. We have many community
6 partners, The Bronx AIDS Services, ACQC in Queens,
7 Bronx AIDS Services of course in The Bronx, and
8 Community Healthcare Network. There are
9 organizations all over New York City, including
10 our school based health programs that address men
11 who have sex with men. There's the LGBT Center in
12 Manhattan, there's GMHC. So, all over New York
13 City, there are organizations that address the
14 special population.

15 CHAIRPERSON RIVERA: Okay, perfect.
16 That concludes my line of questioning for now.
17 I'm going to turn it over to my co-chair, Council
18 Member Lew Fidler.

19 CHAIRPERSON FIDLER: Thank you,
20 Chairman Rivera. Doctor, before I ask you
21 questions about the homeless population that fits
22 into this demographic, I wanted to ask you some
23 more general questions. Because we're talking
24 about a population that's 13 to 17 here, they're
25 necessarily legal minors. Are there any legal

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barriers to these young people seeking services?

MONICA SWEENEY: There are no legal barriers, but many of the minors are not aware of the fact that once they have run away from home, they--

CHAIRPERSON FIDLER: I'm not talking about RHY kids now, I'm just talking about any 13 to 17 year old.

MONICA SWEENEY: There are no legal barriers to a 13 to 17 year old seeking reproductive and/or treatments for STDs anywhere in New York City.

CHAIRPERSON FIDLER: Oh, if a 14 year old presents and they are, they test HIV positive, there are no legal barriers to services.

MONICA SWEENEY: You can test at any age without rega--any age, regardless of age, can test without, and give consent for testing, but you know we still have to get separate written consent--

CHAIRPERSON FIDLER: Right.

MONICA SWEENEY: --without regard to age in New York.

CHAIRPERSON FIDLER: And can

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2 services be provided to a 14 year old who tests as
3 HIV positive, without any, the involvement of
4 parents or any other individuals?

5 MONICA SWEENEY: Many organizations
6 interpret that they will test you and give you a
7 diagnosis, knowing that there are no age, lower
8 age limit for doing that, as long as you
9 understand. But many organizations hedge when it
10 comes to treating. However, if you're--

11 CHAIRPERSON FIDLER: Is that, now
12 is that a legal, is there a legal standard that
13 proscribes that? Or is it just some other
14 objection?

15 MONICA SWEENEY: Squeamishness
16 about legal issues. In the STD clinics, we teach,
17 we treat anyone who comes to the sexually
18 transmitted disease clinics, without regard to
19 age. If you show up and you think you have an
20 STD, you are tested, screened and treated without
21 regard to age. There are other organizations that
22 are more, have more reservations about it, and,
23 and makes it somewhat more difficult. In terms of
24 pregnancy or reproductive health issues, most
25 organizations will treat you.

2 CHAIRPERSON FIDLER: But is that,
3 doctor, is that a matter of the policy of those
4 organizations, or state law, federal law, city
5 law? I mean, where does that hesitancy come from?

6 MONICA SWEENEY: It's a matter,
7 it's a matter of interpretation of the law, which
8 is explicit about testing for HIV, but not
9 explicit about treating.

10 CHAIRPERSON FIDLER: And is that
11 state law or federal law?

12 MONICA SWEENEY: State law.

13 CHAIRPERSON FIDLER: Okay. I guess
14 we need to talk to our state colleagues about that
15 ambiguity. Now, those are, those go to the legal
16 barriers, and obviously there are non-legal
17 barriers to a 14, 15, 16 year old seeking
18 services. And obviously, the standard, the
19 practice that you have of reaching kids through
20 high school and whatnot, is effective because
21 that's where kids are, and you have to reach them
22 where they are. But I can well imagine that a 15
23 year old high school student may be a little bit
24 hesitant to present themselves to someone at the
25 high school, and say, "I think I may be HIV

1
2 positive, I may have an STD." What, you know,
3 what are you doing procedurally to deal with that
4 reality?

5 MONICA SWEENEY: What is done
6 procedurally is that many students, as you may
7 recall from the testimony, about twice as many
8 students were tested as received the education.
9 So the procedure is set up in a way that the
10 education is conducted, and then all the students
11 are given the equipment necessary for the testing,
12 but only those students who feel comfortable doing
13 it, are then tested. So you're not outed by the
14 fact that you take the cup, for example, because
15 everybody gets the same equipment, and then you
16 decide whether or not you want to be screened and
17 return a specimen or not. So that it does not out
18 you as being somebody who may think that there is,
19 that you have an STD.

20 CHAIRPERSON FIDLER: No, you ran a
21 quick statistic at me, that you said that twice as
22 many people, you can't have more people being
23 tested that are getting the education, can you?

24 MONICA SWEENEY: No, half as many,
25 twice as many people receive the education as were

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tested.

CHAIRPERSON FIDLER: So 50 percent choose not to find out.

MONICA SWEENEY: That's right, of the ones that, yes, of the ones that came for the education.

CHAIRPERSON FIDLER: Do you have any idea what percentage of the kids who are getting the education are sexually active?

MONICA SWEENEY: No, we don't know.

CHAIRPERSON FIDLER: But we don't, we don't know whether or not there are sexually active young people who are declining both the education and the test.

MONICA SWEENEY: And the test, no, there's no way to know.

CHAIRPERSON FIDLER: Okay. And we've been joined by Councilman Mitchell. Now, I just want to segue way that to the runaway and homeless youth population, and which, you know, I have a district interest. Obviously, if you're reaching kids through the internet, not likely to get an RHY kid that way. If you're reaching kids through high school, not likely to get an RHY kid

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2 that way. What efforts is the Department making
3 to reach young people who are in fact disconnected
4 and/or homeless?

5 MONICA SWEENEY: There are many
6 programs that are funded. One example being Safe
7 Horizons, where youth are referred who are
8 homeless or unstably housed, or have other issues
9 where they are, they take them in and work with
10 them. I think the, for 90 days, to get them
11 placed in, in housing. There is also Ali Forney
12 which is another--

13 CHAIRPERSON FIDLER: The Health
14 Department funds Safe Horizons and Ali Forney?

15 MONICA SWEENEY: Yes.

16 CHAIRPERSON FIDLER: Okay.

17 MONICA SWEENEY: And others. We do
18 HIV testing in homeless shelters, as well, where
19 of course many of the runaways find themselves, at
20 homeless shelters.

21 CHAIRPERSON FIDLER: Are you
22 talking about DHS homeless shelters or DYCD
23 homeless shelters, or both?

24 MONICA SWEENEY: Or both.

25 CHAIRPERSON FIDLER: Okay.

2 MONICA SWEENEY: And so, when--and
3 of course, when youth who are leaving the penal
4 system are leaving, and there are facilities to
5 help them reintegrate into the community, and we
6 also fund that effort.

7 CHAIRPERSON FIDLER: You offer
8 testing to every young person who's leaving Rikers
9 Island or--

10 MONICA SWEENEY: We try to offer
11 testing when people are entering.

12 CHAIRPERSON FIDLER: Well, let me
13 hear that again, you try to offer testing?

14 MONICA SWEENEY: That is correct.

15 CHAIRPERSON FIDLER: Or you do
16 offer testing.

17 MONICA SWEENEY: We do offer
18 testing.

19 CHAIRPERSON FIDLER: Okay.

20 MONICA SWEENEY: However, the
21 circumstances around people entering Rikers Island
22 are such, when many people get there, they've been
23 up for a very long time, they're hungry, tired,
24 angry and other things, they don't all accept.
25 But testing is offered, and we presently have a

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2 system that is being funded to try and--that goes
3 back and looks at people who refused testing, to
4 test them at another time during their
5 incarceration.

6 CHAIRPERSON FIDLER: Well,
7 obviously you can't force people to take the test.
8 I just want to make sure that everybody is, knows
9 that there, that it's being offered. Now we, we
10 have found that there is a tremendous correlation
11 between both incarceration and aging out of the
12 foster care system with homelessness. What about
13 kids who are leaving foster care? Are they
14 offered the opportunity to test? How about kids
15 in foster care? Are they offered the opportunity?

16 MONICA SWEENEY: I cannot say
17 specifically about leaving. Many foster care
18 agencies require an HIV test before--I've worked
19 with foster care agencies in the past--they
20 required an HIV test before you were placed in the
21 foster care.

22 CHAIRPERSON FIDLER: They require
23 it? I didn't think the law permitted requiring
24 HIV tests.

25 MONICA SWEENEY: Many of them--

2 CHAIRPERSON FIDLER: Are you sure?

3 MONICA SWEENEY: Many of them
4 definitely encourage--

5 CHAIRPERSON FIDLER: There's a
6 difference between requiring and encouraging, and
7 I'm not trying to play gotcha with you--

8 MONICA SWEENEY: They, they enc--

9 CHAIRPERSON FIDLER: --I'm just
10 trying to understand.

11 MONICA SWEENEY: They encourage HIV
12 testing before you're placed in foster care.

13 CHAIRPERSON FIDLER: Well, I, I
14 think they ought to encourage it before you leave,
15 too, because there is a direct pipeline from
16 foster care to the streets of New York,
17 unfortunately, and ashamedly. Now you did
18 indicate to Chairman Rivera that you had some very
19 specific data about the 80 people in this age
20 category who presented as HIV positive in 2008.

21 MONICA SWEENEY: That we will
22 provide you--

23 CHAIRPERSON FIDLER: Yes.

24 MONICA SWEENEY: --after the
25 hearing, yes.

2 CHAIRPERSON FIDLER: Do you know
3 how many of those were homeless?

4 MONICA SWEENEY: I don't have the,
5 the data with me about those 80 adolescents who
6 were HIV positive, but we will, if you give us the
7 questions that you want answered about them, we
8 will give you the answers to the extent that we
9 have them.

10 CHAIRPERSON FIDLER: I would ask
11 you to provide all the information that you have
12 about them, I'm not interested in their names, I'm
13 interested in everything else, because quite
14 frankly I could give you a list of things I'd like
15 to know, and it may be something that I'm too
16 ignorant to ask, that might be the most, you know,
17 relevant thing that I could find for me.

18 MONICA SWEENEY: Will do.

19 CHAIRPERSON FIDLER: So I'd like to
20 see it. And I guess before I turn it over to
21 Councilwoman Gonzalez, who I think is first on our
22 question list, I was informed, and I actually
23 think it came from our representative from Safe
24 Horizons on our Runway and Homeless Youth
25 Taskforce, that they have seen an increase in the

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2 number of runaway and homeless youth that are
3 presenting as HIV positive. And they're not,
4 they're not certain whether it's an increase in
5 testing or if it's an increase in the amount of
6 sex work that's being, become, you know, even more
7 prevalent in this population, or whether it's an
8 actual increase in the transmittal of the virus.
9 Is the Health Department aware of, of that, you
10 know, that position, you know, that has been
11 represented by Safe Horizons? Do you agree with
12 it? And have you responded to it in any way if
13 you do?

14 MONICA SWEENEY: The, the number of
15 people who are becoming infected, we gave a total,
16 an aggregate number for the years that we are
17 presenting, since HIV has been a reportable
18 disease. Two, we know the numbers are going up in
19 that age group, but specifically whether or not
20 they represent runaways or homeless is not a
21 statistic that I can give you.

22 CHAIRPERSON FIDLER: I would just
23 conclude by saying I think it's extraordinarily
24 important that, that you do know, I mean, not
25 necessarily sitting here, but I think you need to

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2 go back and look, because if, if this demographic
3 is showing an increase in HIV positive cases, and
4 if you can discern that, you know, that increase
5 is coming from, from homeless kids, then you need
6 to step up, I mean, I think you probably need to
7 step up the effort citywide anyway, all along, not
8 just for homeless kids, but I think you need to,
9 to step up the effort, particularly by working
10 with groups like Safe Horizon, Ali Forney, the
11 Door, Green Chimneys and whatnot, all of our
12 providers and runaway and homeless youth, the
13 drop-in centers that we, that we have, to stem
14 that tide. Because if that's where your increase
15 is coming from, then you need to be directing
16 resources where the increase is coming from, so we
17 can turn that, that trend around. So, I, I look
18 forward to receiving the data on those 80. I'm
19 going to look at it very, very carefully, and, and
20 ask that the department, you know, look at it
21 carefully, too, because we need, the resources are
22 far too scarce to begin with, and we certainly
23 need to be using them where they are demonstrating
24 the greatest, the greatest need, and that would be
25 where there's an increase.

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2 MONICA SWEENEY: We will definitely
3 get you all the data that we have on those 80 new
4 cases from 2008. All that we collect, we will
5 give to you.

6 CHAIRPERSON FIDLER: Thank you,
7 doctor. Councilwoman Gonzalez?

8 COUNCIL MEMBER GONZALEZ: Thank
9 you, Chair. Good afternoon, Commissioner.

10 MONICA SWEENEY: Good afternoon.

11 COUNCIL MEMBER GONZALEZ: I just
12 want to say that in Brooklyn, specifically
13 district 38, I, in the '80s, into the '90s, I
14 believe that we probably lost over 500 families,
15 including children, to HIV/AIDS. It then, I
16 believe we were, Brooklyn was like number two in
17 respect to infection, it had to do a lot with IV
18 drug abuse. And so, I just want to ask you a
19 couple of questions in reference to your
20 testimony, or your presentation today. You spoke
21 a little bit about the street involved youth
22 organizations. Tell me a little bit about that,
23 how that works, 'cause you spoke about membership,
24 you, your, your being involved as members, is that
25 what I understood?

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2 MONICA SWEENEY: Yes, there are
3 staff from DOH who works with these groups to try
4 and coordinate a more--thank you-a more
5 coordinated landscape, so that everyone who's
6 working on this, these vulnerable populations,
7 know what each other's doing, and know--thank you--
8 -so that everyone who's working with these
9 vulnerable populations are coordinating their
10 efforts, and so that everyone knows what services
11 they are and can look for which gaps there are,
12 and, and know, and be involved with what needs to
13 be done more of or less of.

14 COUNCIL MEMBER GONZALEZ: Is there
15 any thought in respect to peer? For example, you
16 spoke about having identified 80 MSM, I believe
17 that's what you said earlier, in respect to being
18 infected or whatever, at this point. Is there any
19 possibility of thinking possibly about peer
20 programs? And also, in my community, there,
21 people have different, you know, lifestyles, and
22 so people don't so quickly identify because there
23 is a lot of stigma, today. So, I guess my
24 question is, if you've assessed these people and
25 you know there's a need in a specific area, what

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2 are you doing there? And what does it involve?
3 You spoke about them being tested, but some people
4 just don't want to be tested, they're scared, they
5 really don't know what they're going to face. Are
6 they getting an educational one-on-one? 'Cause
7 years ago, we had to really clearly explain to
8 folks what they're going to deal with. And today,
9 though it is devastating, there's still a lot of
10 incredible medical help out there. So, years ago,
11 people, when they were identified and they were
12 tested HIV positive, it was like a death sentence
13 for them. Today, people live longer, so I'm just
14 asking, is there any educational that goes with
15 it? Does it cost money, is it something--of
16 course it costs money, but I'm just saying, is
17 there something that we could do in the Council
18 for the future, in respect to budget, instead of
19 being part of memberships? How do we actually get
20 into the community based organizations that need
21 the assistance, in respect to the communities that
22 are impacted and affected? And I'll just close
23 with this in saying, and maybe you don't have the
24 answers, maybe we can get together at a later
25 time. But, you know, I, in doing my campaigning

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2 the last few days, I had a young man that came up
3 to me who was today 16 years old. His parents
4 both died of HIV/AIDS, and he was not touched.
5 His sister was. So, I mean, we continue to live
6 it, and people are still trying to deal with it.
7 And I know that according to your numbers and
8 according to this hearing, it is about men having
9 sex with men today, and respect to homeless.
10 That's another issue that I have, because I also
11 chair Juvenile Justice Committee. So I'm really
12 concerned about young people that are detained,
13 and how we can give them as much information.
14 Because you can't ask them to be tested, you can't
15 force them, but at least if you give them some
16 kind of educational, and you explain to them what
17 the ramifications of their behavior in an
18 environment that's conducive to that, then that
19 may work. I'd love to be able to sit with you and
20 talk to you, and I want to thank the Committee
21 because this is an excellent hearing. And we do
22 have to step to the plate, because it is about the
23 future. And too many people have died of
24 HIV/AIDS. Thank you.

25 MONICA SWEENEY: I do welcome the

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2 opportunity to meet with you. Our staff would
3 like to at any time. But just to mention that we
4 fund many programs in the community that involves
5 peer leadership. From education to education
6 about reducing stigma, to network testing where
7 people in a certain network would bring in their
8 friends so that if you're a sex worker, you're
9 more likely to be able to get a sex worker to come
10 to get tested. So we do a lot of peer work and
11 fund a lot of peer work already.

12 COUNCIL MEMBER GONZALEZ: Yeah, and
13 I just also want to say that going into the
14 streets and doing the outreach, I mean, I had a
15 program to the Department of Health many years ago
16 in the '80s, that I was director of, and that
17 works. Going out there and actually meeting the
18 people where they're at; being able to talk to
19 them and ask them questions, and that they feel
20 comfort with you. I think that's very important,
21 'cause we even did that, in respect to the
22 prostitution that we had in our district. And it
23 wasn't about threatening them, it was about
24 saying, "Okay, well, look, if you utilize this and
25 utilize that, eventually you could get tested, but

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2 meanwhile you can understand how it's spread. So
3 I think that's very important. So the outreach
4 and the peer programs, so maybe we can continue to
5 have conversations about that.

6 MONICA SWEENEY: We would like that
7 very much.

8 COUNCIL MEMBER GONZALEZ: Thank
9 you. Thank you, Chair.

10 CHAIRPERSON FIDLER: Thank you,
11 Councilwoman Gonzalez. Dr. Stewart, followed by
12 Dr. Eugene.

13 COUNCIL MEMBER STEWART: Thank you,
14 Mr. Chair. I have a couple questions that I would
15 like to, to advance here. MSM, you stated that
16 there is an increase, and we understand it as an
17 increase. But do you have any correlation as to
18 that increase, could you correlate that to folks
19 who have been incarcerated, or in detention
20 centers? Do you have any figures to show?
21 Because I feel that those, there's a, there's a
22 relationship to that. Do you have anything to
23 show then?

24 MONICA SWEENEY: We have statistics
25 about the number of people being tested in Rikers.

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2 And--we have statistics to show the number of
3 people being tested in Rikers, and the one thing
4 that I can say is, is that the sero-prevalence--
5 that means the percent of people in the general
6 population in New York City, is under one percent;
7 in The Bronx, for example, it's 1.7 overall, and
8 2.2 in some areas. But people in Rikers who get
9 tested, it's six percent of the people who are
10 tested are positive. And in wom--that's overall.
11 And in women, it's even higher than men. So we
12 know that there's an association between
13 incarceration and HIV. But for the 80 people that
14 you're talking about, we don't have those numbers,
15 but we would be happy to provide for you the same
16 data that we're providing to Chairman Fidler about
17 the data that we do have for the 80 people that we
18 tested in 2008.

19 COUNCIL MEMBER STEWART: Well, if
20 you see that correlation there, why is it that we
21 do not make it mandatory that we give folks who
22 are leaving, when they are being discharged, we
23 give them a medical screening, you know, general
24 checkup, before we release them?

25 MONICA SWEENEY: People are given

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2 checkups before they leave prison, but in New York
3 State, HIV is still voluntary in every setting,
4 except rape. And we cannot mandate that anyone
5 gets tested either going in or out of prison, or
6 in any other setting.

7 COUNCIL MEMBER STEWART: So, you
8 think there's a legal barrier, legal problem, in
9 terms of doing that? In terms of testing them
10 from when they leave, when they're being
11 discharged?

12 MONICA SWEENEY: There is not a
13 problem in offering testing, but we cannot mandate
14 testing in any setting.

15 COUNCIL MEMBER STEWART: Alright.
16 What about at the juvenile detention places?
17 They're not, they're not Rikers Island, but you
18 mention Rikers, and what about those juvenile
19 detention centers, where young, younger folks are?
20 And they're being held there, which is a lot
21 looser in terms of their restrictions. What
22 studies have you done or what have been done in
23 those places?

24 MONICA SWEENEY: We are working
25 with the Department of Juvenile Justice to assist

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2 them in doing technical assistance to help them in
3 setting up testing for the juveniles that are
4 there. And the floating hospital is starting to
5 test, also, and giving technical assistance to
6 people who, to programs to test those who are held
7 in juvenile detention.

8 COUNCIL MEMBER STEWART: So, you're
9 saying we haven't done any testing there? We
10 haven't done anything?

11 MONICA SWEENEY: We have been--Oh,
12 there's been testing before, but to have a larger,
13 broader based system for testing. Yes, there is
14 testing, but to expand the program.

15 COUNCIL MEMBER STEWART: Alright,
16 thank you, sir.

17 CHAIRPERSON FIDLER: I just want to
18 be clear before we go to Dr. Eugene, and I made
19 the same omission, obviously a large amount of
20 this population at this age group is not going to
21 Rikers, but is going to whatever they're calling
22 Spofford [phonetic] these days. Do you have, you-
23 -and I heard you say you have a relationship with
24 Juvenile Justice. Is everyone who leaves a
25 juvenile detention facility offered the

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opportunity to be tested?

MONICA SWEENEY: I don't have that information.

CHAIRPERSON FIDLER: Okay, well--

MONICA SWEENEY: It's not usually-- in general, but I do not have that information, but in general, it's not when people are leaving so much as when people are entering, when they do the physical, which they, has to be done on all of them, that testing is offered. Leaving, it's, I cannot answer what is done. But we can send that along, too. But there is a separate department for Juvenile Justice that we're working with.

CHAIRPERSON FIDLER: My recollection from--and Chairwoman Gonzalez can correct me if I'm wrong, that when we toured their facility, they did indicate that a full medical screening is supposed to be done, that would include sexually transmitted diseases, HIV, obviously within the limits of the law. So, I, my, I would've expected that the answer would be yes, and then the question would be, "Do you have data on it that you--" that, I mean, clearly Juvenile Justice must have data on it, and it

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2 would just strike me that one hand ought to be
3 talking to the other, so that you know what that
4 data is.

5 MONICA SWEENEY: In the past, when
6 we've met with Department of Juvenile Justice,
7 there the detainees had to go offsite to get HIV
8 testing, and what we're working with them on now
9 in the floating hospital is working with them on
10 now, is to be able to test on site. Because the
11 greater effort and the more barriers you put up,
12 of any kind to people being tested, the less
13 likely they are to get tested.

14 CHAIRPERSON FIDLER: I have to tell
15 you, if, if that is in fact the case, that they
16 have to leave the site to be HIV tested, that's
17 just criminally irresponsible. That is, that is
18 absolutely outrageous. I mean, it is hard enough
19 to convince someone to step up and be brave enough
20 to take the test, if they're concerned, yet you
21 have them there, they're getting the rest of their
22 medical treatment right there. if they have to
23 leave the DJJ facility to be tested for HIV,
24 that's just stupid. I mean, I just, I'm just
25 amazed to hear that, and I, I just hope that's

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2 inaccurate, and we'll be reaching out to, to the
3 Commissioner to, to make sure that is in fact not
4 the case. 'Cause if it is, that's got to change.

5 MONICA SWEENEY: Well, that was the
6 case, but I can't speak for this minute.

7 CHAIRPERSON FIDLER: I, I sure hope
8 it's not the case, because I mean that's just, you
9 know, it's insane. Dr. Eugene?

10 COUNCIL MEMBER EUGENE: Thank you
11 very much, Mr. Chairman. I want to congratulate
12 and commend, you know, your office for what
13 they're doing, you know, to fight against
14 HIV/AIDS. But as you know, we all know that much
15 more need to be done. But let me ask you, in
16 terms of the all the population of young people
17 who are not in school, like those who belong to
18 other communities, who either don't speak English
19 properly, those who are not completely integrated
20 in this system. What type of outreach that you
21 use to reach them out, and to educate them, also?

22 MONICA SWEENEY: If they are in
23 school, you're saying, or out of school?

24 COUNCIL MEMBER EUGENE: Out of
25 school. And those who belong to the non-

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2 proficient English communities, for example.

3 MONICA SWEENEY: Much of the
4 literature that is produced by the Department of
5 Health is in multiple languages, including
6 Haitian, Creole, Spanish, Chinese, and so forth.
7 And the people that are in the communities when we
8 fund community based organizations, they often are
9 the ones who, right in the community are the ones
10 who determine the need for services in other
11 languages, once they are funded for special
12 programs.

13 COUNCIL MEMBER EUGENE: Beside the
14 community based organization, do you have any
15 connection, or any partnership with the churches,
16 the pastors?

17 MONICA SWEENEY: We have a faith
18 based program where we are engaging churches,
19 where we ourselves go out and give talks. We have
20 a faith based office that is involved in--all a
21 church has to do is ask us, but even when they
22 don't ask us, we often ask them. And we are
23 involved in giving talks in churches, and reaching
24 out to support them in many of their activities
25 when they have activities in their churches.

2 COUNCIL MEMBER EUGENE: There's a
3 very big issue right now, when we talk about have
4 coverage and have services, non-documented people.
5 You know, we should think about the non-documented
6 people, this is a have issue, very big have issue
7 for us. What type of program or outreach, how do
8 reach the non-documented people? And what type of
9 services that you provide to them?

10 MONICA SWEENEY: You know, the one
11 thing that I often say in many of my talks to
12 churches and other organizations when I'm
13 speaking, is that the best place to have HIV, and
14 the best place to have HIV is no place, but if you
15 have to have it, New York City is the best place
16 to have it, because we have services for people
17 regardless of their ability to pay, and regardless
18 of their documentation. And the, from the federal
19 government, we receive funds specifically for
20 people who are not documented, to receive HIV
21 care.

22 COUNCIL MEMBER EUGENE: Can you
23 just mention some of the services that you're
24 talking about? Just some example.

25 MONICA SWEENEY: Primary care, all

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2 medical care, medications, all of the care that
3 you need to negotiate the system and to get the
4 care you need to stay healthy with HIV, all of it.
5 Transportation to appointments, the medical care,
6 the doctor's visit, all of it, is available to
7 those that are undocumented.

8 COUNCIL MEMBER EUGENE: Beside the
9 medical care, or medical services, is there any
10 other support services that you provide to the
11 people, you know, affected by HIV or - - of being
12 affected by HIV? Any other support services,
13 counseling or--?

14 MONICA SWEENEY: Counseling--

15 COUNCIL MEMBER EUGENE: Not for
16 those in school.

17 MONICA SWEENEY: Counseling, mental
18 health services, the full range of medical
19 services are available. Everything that is needed
20 to engage a person, and first test them. Find out
21 their status, then engage them in care, and then
22 to keep them in care, the full range of services
23 are available to those without insurance and those
24 who are undocumented in New York City, in all five
25 boroughs.

2 COUNCIL MEMBER EUGENE: Thank you
3 very much. Thank you, Mr. Chairman.

4 CHAIRPERSON RIVERA: And next we
5 have Council Member Inez Dickens.

6 COUNCIL MEMBER DICKENS: Thank you
7 so much, Commissioner, and I do commend you for
8 the work that you've done. However, can you tell
9 me what percentage of cuts has HIV/AIDS received
10 from the federal government?

11 MONICA SWEENEY: We, at one point,
12 had a budget of Ryan White, from Ryan White, of
13 \$120 million. And this year's appropriation will
14 probably be, grant will probably be about
15 \$110,000, \$111,000. That's for Ryan White, to
16 take care of the services that I was just
17 mentioning.

18 COUNCIL MEMBER DICKENS: Well, with
19 cuts such as that occurring, and I know on the
20 City Council level, the cuts that we were forced
21 to put, implement, impacted upon counseling and
22 housing, testing and research. We tried to
23 preserve testing. But I'm very concerned about
24 the, the focus and the targeting and the outreach
25 that may not be done to the MSM community, because

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2 of these cuts. I'd like to know from you if you
3 anticipate that in the next budget cycle, if
4 there, you anticipate that, that you might have to
5 have cuts to that, that's one. And the second
6 thing is, how will it impact upon our, the foster
7 care families. Because I agree with my colleague
8 that the foster children should not be just tested
9 when they're going to enter a foster care home,
10 but during the time, and rather than to wait,
11 because it could be a number of years, and that
12 impacts upon the care that they would receive.
13 And because of the federal cuts to imaging and
14 etc., CAT scans and all of that, that is being
15 done across the board, then I know that will
16 impact on HIV and AIDS. And also, I haven't heard
17 anything about dental care for HIV and AIDS, and
18 I'd like to know about what's going on with that,
19 because when you have been diagnosed positive,
20 that impacts upon your teeth. And I'd like to
21 hear something about a program for dental care.

22 MONICA SWEENEY: You know, the, the
23 issue with MSM, young MSM, which is what we're
24 talking about today, is it's an important issue.
25 We will never have the resources to do all of the

1 things that we need to do. However, if we look at
2 the whole picture, whereas MS--young MSM are
3 important, it would not be the top focus of where
4 the resources would be allocated just if we were
5 looking at the proportion of people who get
6 infected. Older MSM are getting infected also.
7 So, we have to look at the whole picture. Having
8 said that, there'll never be enough resources in
9 public health. Having said that, we are working
10 more efficiently ourselves, and asking our
11 partners to do the same. When we are forced to
12 have cuts, we sometimes have to say, "Well, what
13 is it that it's best to do without?" So when
14 there was a cut for say something related, you'll
15 say, "Well, it's easier to do without this support
16 service than it is to do without food," or "It's
17 easier to do without this than it is without
18 that." So there's always the idea that you have
19 to make difficult choices while taking care of, of
20 course, the most basic needs of the people who are
21 infected and affected. Which brings us to dental.
22 There are many people who do not think that dental
23 is basic, and there has been a cut for the
24 programs around dental in HIV, from the Ryan White
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2 program. So that's why you didn't hear any
3 discussion of it. They have been cut.

4 COUNCIL MEMBER DICKENS: Yes, I'm
5 fully aware. Also, just one last question on the
6 faith based initiatives, where you are going into,
7 to many of religious institutions, and they are
8 having significant seminars, etc., around it, but
9 I have gone to many of them but have found that I
10 only saw the literature in English. Does the
11 individual church have to specifically request for
12 specific languages? Or because I do know you have
13 it in other languages other than English. So do
14 they have to ask or do you provide it when they
15 service a community? For instance, in Harlem,
16 Creole French is very, very, a high population,
17 speaking. Now, I haven't found the literature to
18 be in Creole French.

19 MONICA SWEENEY: We have it.

20 COUNCIL MEMBER DICKENS: Maybe
21 Spanish, maybe.

22 MONICA SWEENEY: We have it, and
23 when we are involved in supporting an
24 organization, we show the literature that we have,
25 in faith based organizations, we show the

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2 literature that we have, and ask what languages
3 they want it in. And they have to tell us. And I
4 was recently in one where there was no English,
5 because they had, I guess, used all of it, and
6 there was, there were all the other languages, but
7 not English. So they do have to tell us they want
8 300 of this, and 500 of this, and then we, we fill
9 them based on what their requests are, including
10 cultural sensitivity where some of them don't want
11 certain folders because they show things that they
12 don't want in their congregation. So that we are
13 guided by what their requests are.

14 COUNCIL MEMBER DICKENS: Well,
15 thank you, because that's what I wanted to know.
16 Did they have to request?

17 MONICA SWEENEY: Thank you,
18 Councilwoman.

19 COUNCIL MEMBER DICKENS: Thank you.

20 CHAIRPERSON RIVERA: Council Member
21 Helen Diane Foster.

22 COUNCIL MEMBER FOSTER: Sorry.
23 Thank you very much. Just a couple of brief
24 questions. What are we doing to target, I guess
25 you call them sex workers, the men that are having

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2 sex with men, and in their heads don't classify
3 themselves as homosexual or bisexual, and really
4 look at it as what they need to do for, to
5 survive. And I know that in my area in The Bronx,
6 we have certain areas where that is larger than
7 others. What are we doing to reach out to them
8 and educate them? Because I read through your,
9 your testimony, and, and the MySpace, and
10 different areas. But it would seem to me this is
11 a population that we need to target, but it's also
12 a population that would be more difficult to get
13 through to.

14 MONICA SWEENEY: Well, one of the
15 activities at the Department of Health is that
16 we're doing something called "social network
17 testing," and I had alluded to it earlier. And at
18 social network testing, people from the community
19 who are in the social network. So, if you are a
20 porn star, for example, you would be recruited and
21 trained; or a sex worker, or a drug user or former
22 drug user, you would be recruited and trained.
23 And then you would bring in people from your
24 social network to be tested for HIV. So one of
25 the, this was mentioned earlier when we were

1
2 talking about peers. One of the feelings that we
3 understood clearly from the community, is that
4 the, each group could better reach the group that
5 it is a part of.

6 COUNCIL MEMBER FOSTER: Right.

7 MONICA SWEENEY: And so that's one
8 of our major initiatives now. And the other
9 activity we have is, one of the organizations that
10 we work very closely with in, in the community,
11 has a van and it takes it to various places where
12 they know that there are very hard to reach
13 populations, and they do outreach, education and
14 testing from the van. And it's mobile, and it
15 goes from place to place with, where there's a
16 high prevalence of people who are marginalized, so
17 that they can reach them.

18 COUNCIL MEMBER FOSTER: And if
19 there is a tangible way to measure that, how
20 successful has both the van and the, the peers
21 reaching out to like peers, been?

22 MONICA SWEENEY: I will tell you
23 the way we measure it is in what we call sero-
24 positivity. And the sero-positivity in those
25 groups that we test is much higher than in say the

1
2 hospitals or the health centers. So whereas they
3 test fewer people, more of the people that they
4 test are positive for HIV than in other settings.
5 So that is the measure of success that we know is
6 going on with that, with the social network
7 testing.

8 COUNCIL MEMBER FOSTER: And then
9 what is the next step in terms of the peers,
10 reaching the peers, having the testing, and then
11 what?

12 MONICA SWEENEY: And the next step,
13 which is part of the contract, is not only do you
14 find them and test them, the first test is called
15 a screen test. After the screening test is done
16 you have to do a confirmatory test. After the
17 confirmatory test, is linkage to care. And each
18 one of those steps you get reimbursed for, and the
19 one that you get reimbursed the most for is the
20 linkage to care. Not the screening, not the
21 confirmatory, but the linkage to medical primary
22 care.

23 COUNCIL MEMBER FOSTER: So in some
24 ways, this peer is like the patient navigator for
25 the other one, in terms of the one that tested

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positive. Am I understanding that?

MONICA SWEENEY: Well, they're not the navigators, but they, once they bring them in, and they get the test and they're positive, they are working with an organization who have the other pieces in places.

COUNCIL MEMBER FOSTER: Right, but if, if Inez brings me, I test positive, does she stay with me through this process, or is it just now that I've been brought in and then we go through the, the steps that you outlined--

MONICA SWEENEY: It's different in different organizations, but in general the person who makes the connection as the network connector, is not the person who sees you through the rest of it, even though we are working on a program now where they're patient navigators from the time you're positive--it's starting December 1st--from the time you're diagnosed as positive to navigate you throughout the system, including helping you keep appointments, calling you up to remind you, etc. Because falling out care is one of the major issues that we have.

COUNCIL MEMBER FOSTER: Right.

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2 And, and lastly, how often do you and people from
3 Department of Health and Mental Health, meet with
4 and actually sit down with the providers who are
5 on the front lines, as I'd like to call it, who
6 know what's happening, probably before any of us
7 know, to make sure that, as much as possible, we
8 are ahead of the game, and trying to be proactive
9 in terms of reactive. 'Cause I, I look around and
10 I have some of my, my really good providers in my
11 district, that I know are telling me in and out,
12 you know, this is where I want my money to go,
13 'cause I know they're reaching the people that
14 need services. How often are you, as an agency,
15 in a department, meeting with these providers so
16 that they can tell you what's happening?

17 MONICA SWEENEY: You know, in an,
18 in many times, in an informal way, we have
19 meetings about many subjects. But there's
20 formalized, quarterly meetings, and then we have
21 line staff we call the front line staff in the
22 trenches, who are project officers who interact
23 with them on a daily basis. So they wouldn't come
24 to your organization every day, but they have
25 their five to seven organizations that they

1
2 interact with all the time. They're called
3 project officers.

4 COUNCIL MEMBER FOSTER: And do
5 these project officers then report to whomever as
6 to what we are seeing as trends or things that we
7 need to look out for, or--

8 MONICA SWEENEY: On a weekly basis.

9 COUNCIL MEMBER FOSTER: Okay.

10 MONICA SWEENEY: On a weekly basis.
11 So there are lots of informal meetings for other
12 thins where this happens, but in an organized way,
13 quarterly we have meetings, but also weekly the
14 project officers meet to talk about their five to
15 seven organizations that they're dealing with.

16 COUNCIL MEMBER FOSTER: Okay.

17 Thank you very much.

18 MONICA SWEENEY: Thank you.

19 CHAIRPERSON RIVERA: Thank you very
20 much, Dr. Sweeney. Seeing no other, we've been
21 joined by Council Member John Liu, as well, thank
22 you. And seeing no other questions, thank you
23 very much for your participation. Do you have any
24 questions? We've got--Thank you very much for
25 your participation.

2 MONICA SWEENEY: Thank you very
3 much.

4 CHAIRPERSON RIVERA: We're going to
5 call up the next panel. Calvin Lavelle, from the
6 HEAT program. Harold Hamilton from, from SUNY
7 HEAT program as well. And Jose Davila, from The
8 Bronx AIDS Services. And Lyndel Urbano, from
9 GMHC. [pause] Thank you very much. You can
10 decide who goes first and just state your name for
11 the record. You can provide your testimony to
12 Sergeant Voms [phonetic], he'll pass it over to
13 us, and you may proceed.

14 HAROLD HAMILTON: Good afternoon,
15 Chairman Rivera, Chairman Fidler, and Council
16 Members. My name is Dr. Hamilton. I'm speaking
17 on behalf of Dr. Jeffrey Birnbaum, the Director of
18 the Health Education and Alternatives Program for
19 Teens at SUNY Downstate Medical Center in
20 Brooklyn. The program provides comprehensive
21 medical, mental health and case management
22 services for HIV/AIDS infected 13 to 24 year old
23 adolescents. The program started in '92. HIV and
24 AIDS among young men who have sex with men, ages
25 13 to 17 years old in New York City is a challenge

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2 to address for health providers for a variety of
3 reasons. This is an age group where the interface
4 of sexual exploration and illusions of
5 immortality, associated with adolescent
6 development, cause a high risk scenario for HIV
7 transmission, as well as creating some unique HIV
8 prevention challenges. The epidemiology of HIV
9 transmission in adolescents and young adults in
10 New York City, as well as elsewhere in the USA,
11 can help illustrate some of these challenges. In
12 New York City, during the first half of 2008, 94
13 new cases were identified in the 13 to 19 year old
14 age group, compared to 508 in the 20 to 29 year
15 old age group. During this time period, the rate
16 of newly diagnosed men who have sex with men,
17 YMSM, age 13 to 29, was 266. This number
18 represents an increase from the 253 men in that
19 same category, diagnosed during the same period in
20 the previous year. These number represent higher
21 rates of diagnoses found in the 18 to 29 year old
22 group. What these numbers don't reflect is when
23 the young people are actually getting infected.
24 We know there's a variable lag time between when a
25 person actually gets infected and when they're

1 first diagnosed with HIV through testing. It is a
2 clinical perception of most HIV providers who care
3 for young people that many of these patients they
4 care for in the 20 to 29 year old age group, were
5 infected during their teen years, including the 13
6 to 17 year old age group. During the first half
7 of 2008, 17 percent of the 13 to 17 year old, and
8 16.7 percent of the 20 to 29 year old age groups,
9 had concurrent HIV/AIDS diagnosis, which supports
10 a clinical perception that, of early HIV infection
11 times from when some members of the group were,
12 are newly diagnosed. Several factors play into
13 why 13 to 17 year olds are not diagnosed with HIV
14 earlier. First and foremost is that this age
15 group tends not to access healthcare services,
16 particularly services for HIV testing. The age
17 group may also have a lack of knowledge about
18 where to get an HIV test or other sexual health
19 services, and be concerned about the ability to
20 pay for such services. The providers may have
21 concerns about the rights to consent as a minor,
22 as well as concerns about confidentiality of the
23 sexual behavior and sexual identity in
24 relationship to parental and legal guardians of
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2 these, of the minors served. Providers may also
3 be faced with a potentially, potentially absorbing
4 the cost of providing services to minors without
5 parental consent. 13 to 17 year olds are impacted
6 by the overall poor quality of sex education in
7 schools and HIV prevention education, especially
8 for young men who have sex with men, and a lack of
9 effective HIV outreach and prevention modalities
10 for younger teens. In general, teenagers often
11 are, are often faced with a paucity of age
12 appropriate health services, and tend to fall in,
13 into the cracks between pediatric and adult care.
14 At the HEAT program in Brooklyn, which provides
15 comprehensive services to HIV positive youth
16 between 13 and 24 years. Our patient demographics
17 are also reflective of the epidemiology of HIV in
18 this age group in New York City. Of each current
19 caseload of 90 plus HIV positive, 59 are young men
20 who have sex with men; of these, about
21 approximately 25 percent enter care in the 13 to
22 17 year old age group, and ten of these were
23 already 15 to 17 years old. Of HEAT's historical
24 caseload since 1992 of over 300 HIV positive
25 cases, the total of 82 young men who have sex with

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2 men; of these 82, roughly 28 percent enter care
3 between the ages of 13 and 17 year old. The
4 number of 18 to 24 year olds with HIV increases
5 considerably once they enter this age group,
6 reflective of New York City's epidemiology of new
7 cases of HIV identified. At the HEAT program, our
8 problems with finding younger MSMs who are HIV
9 positive, and engaging them in care, are further
10 complicated by extremely sources of funding
11 directed towards adolescent activity services.
12 For example, performance based funding schedules,
13 such as Ryan White Title I funding through HIV
14 Planning Council and HRA, are based on volume of
15 clients served. And they may serve to discourage
16 community based organizations who serve younger
17 men who have sex with men, from applying for or at
18 least on being awarded moneys because they're
19 unable to produce the desired numbers. Success
20 with this population provides the opportunity for
21 early detection, engagement and retention and
22 treatment, in a developmentally appropriate
23 manner. There's also been a heavy concentration
24 of funding in Manhattan based organizations
25 compared to Brooklyn, Queens, Staten Island and

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2 The Bronx. At the HEAT program, we have found
3 that we are successfully able to engage young men
4 who have sex with men, and treat them in their
5 own, in their community--Sorry. Finally, as a
6 member of the Empire State Coalition for Runaway,
7 Homeless and Street Involved Youth, I add that the
8 population of YMSMs is vulnerable to housing
9 problems as sexual orientation may contribute to
10 being expelled from living with their families.
11 In turn, housing issues increase the HIV risk for
12 this vulnerable population as they engage in sex
13 work, substance abuse, and are impacted by mental
14 health problems.

15 CHAIRPERSON RIVERA: Whoever wants
16 to go next is fine. Just state your name for the
17 record, and you may continue.

18 Good afternoon, Mr. Chairman of the
19 Health Committee, and Mr. Chairman of the Youth
20 Services Committee, and distinguished members of
21 both Committees. My name is Jose Davila, and I'm
22 the Executive Director of Bronx AIDS Services, one
23 of the oldest AIDS service organizations in the
24 City of New York. We are the largest provider of
25 non-medical services for persons at risk or

1 affected by HIV/AIDS in the borough of The Bronx,
2 serving over 8,000 clients a year. More than a
3 year ago, I came before you to discuss the
4 precarious state of funding and programming, to
5 address the needs of MSM of color infected or
6 affected by HIV/AIDS in New York City. For months
7 before that, and for months after, BAS and a
8 number of a other community based providers who
9 identified ourselves as the Emergency Response
10 Coalition for MSM of Color, prepared to have these
11 discussions with you and the City Department of
12 Health. Our task was to come up with a plan to
13 address the tremendous need for culturally,
14 linguistically and technologically relevant
15 interventions that isn't met and it is hampering
16 our ability to make sustainable changes in risk
17 and health behaviors among this population.
18 Numerous hours from our agency staffs were
19 dedicated to a thorough and evidence based
20 analysis of those needs, which were incorporated
21 into a white paper that was to be presented to,
22 and discussed with, the then City Commissioner of
23 Health, Dr. Thomas Frieden. The meeting never
24 happened. And frankly, and with all due respect
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2 to this esteemed body, I think I speak on behalf
3 of many of my colleagues and the clients that we
4 represent, when I say that we're tired of talking
5 and writing. We need action and we need it now.
6 In the year that we've been talking, writing and
7 waiting, approximately 675 young men of color who
8 have sex with men were infected by HIV in New York
9 City. How many more young men's health and lives
10 are expendable before we act? The surveillance
11 data is clear: during the first half of 2008, the
12 last period on which we have surveillance reports
13 in New York City, almost 50 percent of all new
14 infections were attributed to MSM contact; and 20
15 percent of those were among the ages of 13 and 29.
16 This disease is decimating our young generation
17 and we need to stop it now. I urge the Health
18 Committee and the City Council in general to
19 request that the City Department of Health address
20 this crisis without further delay. We in the
21 community based service sector stand ready to
22 collaborate, implement and act jointly with them
23 to address the needs of this population. But no
24 more talking please. Thank you.

25 CHAIRPERSON RIVERA: Thank you,

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2 sir. Next?

3 LYNDEL URBANO: Good af--good
4 afternoon. My name is Lyndel Urbano, Manager of
5 Government Relations at Gay Men's Health Crisis.
6 As a City, we must do more to reduce the rate of
7 HIV infection among our youth. There are many,
8 there are 30 concrete steps that we must take to
9 tackle this challenge. First, we must make HIV
10 education more widely available in New York City
11 schools. A lack of science based prevention and
12 comprehensive sex education puts our youth in
13 danger. According to the National Youth Risk
14 Behavior survey, almost half of high school
15 students in the United States report, report being
16 sexually active. Because youth are not receiving
17 adequate information about protecting themselves
18 when they choose to engage in sexual activity,
19 four million young people in the United States
20 contract STDs every year. In December 2007, the
21 New York City Department of Education adopted a
22 supplemental curriculum to its comprehensive
23 health education curriculum, that includes sex and
24 HIV education. However, almost two years later,
25 it has not been widely implemented because sex

1 education is not mandated by the New York City
2 Department of Education, meaning that school
3 principals decide whether or not to include sex
4 education in their school's curriculum. This
5 means that the information shared with each school
6 is not determined by the City or state, and can
7 vary by school and class. For HIV education to be
8 effective, the City Department of Education should
9 mandate specific requirements for HIV/AIDS
10 prevention and education, and monitor this
11 provision in every public school. We must also do
12 more to encourage LGBT affirmative interactions in
13 schools. The most recent national school climate
14 survey conducted by the Gay, Lesbian and Straight
15 Education Network, GLSEN, found that 64 percent of
16 LGBT high school students reported that they had
17 been verbally harassed in the past year, because
18 of their sexual orientation; and 46 percent
19 because of their gender expressions. Studies show
20 that an unsafe educational atmosphere can push
21 students out of school and into high risk
22 behavior. A Massachusetts Department of Education
23 study found that in schools with gay/straight
24 alliances, and other gay affirming interventions,

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2 young gay and bisexual men were less likely to
3 engage in high risk behavior that in schools
4 without these interventions. Again, the tools
5 exist to address this problem, but they are not
6 being widely implemented. The New York City
7 Department of Education has put together a
8 curriculum called "Reducing the Risk" that
9 attempts to address some of these, some of the
10 issues of bias in the schools, but it is not being
11 widely implemented. One in seven New York City
12 high schools has a gay/straight alliance, for
13 example, which is far too few. To be truly
14 effective, the New York City Department of
15 Education should fully implement the Dignity for
16 All Students Act. Finally, a study earlier this
17 year in the Journal of Pediatrics documents that
18 family rejection of gay, lesbian and bisexual
19 youth correlates with poor health outcomes. LGB
20 youth who are rejected by their families are over
21 three times more likely to be, to report having
22 engaged in unprotected sexual intercourse,
23 compared with peers from families who accept them.
24 It is essential that the New York City Department
25 of Health support efforts to implement social

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2 marketing campaigns that promote parental
3 acceptance of young MSM. Right here I have an
4 example of such a campaign that GMHC ran targeting
5 neighborhoods throughout the City in spring of
6 2008. Unfortunately, because of funding
7 constraints, we were unable to distribute it
8 widely, as widely as we would have liked. I mean,
9 we do have it online, on MySpace, and on other
10 websites, but we would've really have liked to
11 spread it out around the City and really get the
12 message out. If we take action now, by promoting
13 sex education, gay affirmative school
14 interventions and family acceptance of gay and
15 bisexual sons, we can still stem the tide of HIV
16 infection among young men who have sex with men in
17 New York City. Thank you for this opportunity to
18 testify.

19 CALVIN LAVELLE: Good afternoon.

20 My name is Calvin Lavelle. I'm 22 years old and I
21 am an HIV positive, black, gay man. But don't
22 pity me because I am one of the lucky few that can
23 actually come here today and speak to you guys. I
24 grew up in Springfield Gardens, Queens. I have
25 the strongest mother on the planet that worked her

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2 butt off trying to--raising me and my sister as a
3 single parent. I finished high school early, a
4 year early, graduated my undergrad in college with
5 a 3.4 GPA, and currently I'm attending grad
6 school. You can applaud. [applause] Thank you.
7 On the surface, everything was perfect, all I had
8 to do was maintain the smile on my face, and the
9 good average, and nobody asked any questions. So
10 I raise this question to the room and to you guys
11 sitting up here on the panel: How does the model
12 teenager such as myself become HIV positive,
13 behaviorally HIV positive? Maybe it's the, maybe
14 it was the attractive 30-something year old man
15 that lived up the block from me when I was twelve
16 years old that saw a little sparkle in my eye. I
17 didn't even realize I was gay yet, but, but he
18 did. I didn't even understand what sex was, bur
19 for two years, he sexually preyed upon me. And
20 then all of a sudden, he moved away and I never
21 heard from him again. Here I am, a 15 year old
22 teenager now, that's been having sex with this man
23 since I was twelve years old, and this man just
24 disappeared. He told me I was great, I was sexy,
25 he would do anything for me, and I believed him.

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2 Why shouldn't I have? For years he kept telling,
3 he kept this dark secret and he performed all of
4 these physical sexual acts that felt good, even
5 though a part of me didn't, thought it was wrong,
6 but it felt good. And then, he told me that all
7 of these things that he was doing was all
8 beneficial for me, and it wasn't beneficial for
9 him. Well, let me tell you something, now that
10 I'm older, I realize how naïve I was. After he
11 leaves, I discovered this new country I like to
12 call the internet. And I would meet older guys on
13 AOL chat rooms, here and there, here and there,
14 and it wasn't until I turned 16, until I admitted
15 that I was in fact this thing that the black
16 culture labeled as being a fag. I'm not 18 years
17 old, it's the summer, I'm a freshman transitioning
18 into my sophomore year in college, and I meet this
19 man. We'll call him Ty. He's now 41 years old
20 and, but he doesn't look a day over 27. This man
21 charmed me, said all the right things, took me out
22 to one of the many restaurants he managed. He
23 gave me clothes, gave me money whenever I asked,
24 he let me stay in his apartment, and he told me
25 anything I needed to hear. When I walked with him

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2 in public, and when I say in public, I'm talking
3 about probably the gay ballroom scene, Christopher
4 Street, because you know, when you're 18 you're
5 just starting to go to the clubs. Before that,
6 the Village is where the gays hang out, because
7 you can't go anywhere else. When other gay guys,
8 when all my other peers saw me with him, they
9 gagged 'cause they were jealous, and it fed into
10 my ego. So, one night, as we are having sex, we
11 started using a condom, but midway through he
12 decides to just take it off. I asked him to put
13 it back on quickly, but he didn't, and you know
14 what? I didn't protest him again after that one
15 time I asked, because I didn't want to risk
16 upsetting this man that had gave so much to me.
17 One month later, I got to a clinic, get a rapid
18 HIV exam, and then he tell, and then I am told I
19 am HIV positive. But thank goodness I enrolled
20 into care, my mom had family health insurance, and
21 my loved ones rallied and supported me. But I'm
22 lucky. Why? Why am I so lucky? Maybe because
23 I'm not my HIV positive friend Mark who lives in a
24 shelter in The Bronx. He can't get a job, he
25 can't get an apartment, because he didn't finish

1 school and he doesn't have access to make a
2 résumé, he doesn't even know how to make a résumé.
3 So, to get money, he sells his HIV medication, or
4 he goes and prostitute on West 10th Street,
5 perpendicular to Christopher Street. If you guys
6 don't know about that street, I suggest you go
7 there around 2:00-3:00 o'clock, I'm sure you guys
8 would see something. Or maybe I'm lucky because
9 I'm not my friend O who lived his life on cocaine
10 and weed, and committed suicide after discovering
11 he was HIV positive at the age of 19. He didn't
12 tell any of us, and I didn't learn this until
13 after he committed suicide, but if only he
14 would've known that he was in the right company.
15 Or maybe because I am not my 17 year old friend
16 Jason, that discovered that the guy he had
17 unprotected sex with last month on the 28th of
18 2009, was the same guy that infected me. True
19 story, can't make this stuff up. But I'm lucky
20 because I had the resources to get help. But what
21 about my friends? The irony is I had every
22 advantage over them, and we all still ended up in
23 the exact same place: HIV positive. Maybe I
24 ended up positive because it was my lack of self-

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2 confidence; maybe it was because nobody ever asked
3 how was I doing; maybe it was because as a young
4 black man, whether you're gay or straight we're
5 taught to be strong and pretend everything is
6 okay; maybe it's because I didn't have the strong
7 male influence my father should have provided me.
8 But I say to you again, do not pity me, because I
9 am lucky that I am able to come here today in
10 front of you and tell my story and my friends'
11 story, the story that my friends, Jason, O and
12 Mark, are not able to tell. Thank you.

13 [applause]

14 CHAIRPERSON RIVERA: Thank you very
15 much. I want to thank each and every single one
16 of you, personally, because it's your life
17 experiences and your expertise, you know, that we
18 crave in the Council to be able to see what
19 direction we're going to go in, in terms of, you
20 know, possible legislations, resolutions and, you
21 know, budgetary actions. Obviously there is a
22 tremendous need out there, obviously there's
23 demographic, does need a lot of resources, and you
24 know, I'm committed, and I know my colleagues are
25 committed to work, you know, directly with you,

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2 because you want to see these numbers decline as
3 well. You know, I want to thank Jose because I
4 know him personally from The Bronx, and I want to
5 thank everybody here. And I think this is your
6 second time, you were here with, during the first
7 one, so, you know, you're experience was
8 compelling, you know, sharing your experiences in
9 the past was compelling with us, and it's still
10 compelling today. And I want to congratulate you
11 because you're showing that you're not taking your
12 situation as 100 percent negative situation.
13 You're sharing your experience, trying to help
14 other people, and that's important. You know, the
15 peer counseling and peer one-on-one, you know, and
16 the contribution you provide, that's vital to
17 making sure we can spread the message, you know,
18 to people within this, the 13 to 17 and the
19 younger demographics. So I applaud you. Thank
20 you. Okay, at this point in time, we have no
21 questions. I want to thank each and every single
22 one of you. We have one more panel, and we do
23 have budget negotiating taking place as we speak,
24 so unfortunately both chairs, Lew and myself, and
25 Inez and Helen will have to go to B&T, but Council

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2 Member Kendall Stewart is going to chair the
3 duration of the hearing. We only have one more
4 panel that's left to speak, and I want to thank
5 everyone for coming out here today for this
6 subsequent hearing. Thank you. I will call the
7 panel up. Jaron Megolanez, Craig Cobb, as well,
8 and Jacobi Johnson.

9 CHAIRPERSON FIDLER: And I, I want
10 to also extend my apologies to this, particularly
11 this last panel. We've got a number of committees
12 going on simultaneously, I had Education next
13 door, and as the Chairman said, some of us are on
14 the budget negotiating team. I think we may
15 actually be working on some AIDS dollars
16 downstairs. I do want to just say that every now
17 and then you hear something at a hearing, that
18 makes you need to put in a piece of legislation,
19 and while I was sitting here, I just handed to the
20 Committee counsel a request to draft up a piece of
21 legislation that would require anyone, that anyone
22 who has, is leaving a DJJ facility, a corrections
23 facility, or foster care, be offered an HIV test
24 in the most convenient manner possible. And if
25 they choose not to take it, that they need to sign

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2 an acknowledgement that they were offered the
3 test, and that they declined it, and that if they
4 do take the test, that the agency then has an
5 obligation to follow up with that individual, let
6 them know what the result was, and provide
7 counseling for how they can get healthcare if the
8 test result is, you know, suggests it. So,
9 hopefully that is something that, positive that
10 will come out of this hearing, so that, you know,
11 we are able to make sure that testing is given to
12 everybody who was at risk, in the most convenient
13 way that they possibly can. [applause] Again, I
14 apologize for having to leave, and I turn this
15 over to Council Member Stewart.

16 COUNCIL MEMBER STEWART: Well, sir,
17 the first thing you do is identify yourself and
18 then, I think you can start on the right.
19 Identify yourself and get straight into your
20 testimony.

21 JARON MEGOLANEZ: Jaron Megolanez
22 [phonetic]. Honorable members of the Committee,
23 my name is Jaron Megolanez, and I work for the
24 Asian and Pacific Islander Coalition on HIV and
25 AIDS, or APICHA. Our mission is to end stigma on

1
2 HIV and AIDS and those affected by it, to prevent
3 the spread of the HIV/AIDS pandemic in the Asian
4 and Pacific Islander communities, and to provide
5 care and treatment for APIs living with HIV and
6 AIDS and their families. I serve as the program
7 manager of LGBT services, as part of the agency's
8 HIV prevention unit. I'm here today to testify on
9 behalf of my agency, but especially on behalf of
10 all young API men living in New York City.

11 APICHA's efforts to prevent the spread of HIV are
12 increasingly effective for many individuals, but
13 because of limited access to the population we are
14 discussing, we are unable to deliver similar
15 services to young gay men. Today, I am making
16 three recommendations to the Committee. Number
17 one, we strongly believe that the greatest need of
18 this population is gay affirming messages. Number
19 two, we strongly recommend funding be directed
20 towards delivering these messages using new media
21 tactics, such as FaceBook, blogs and YouTube. And
22 number three, we as that any new program or
23 initiative be culturally competent and considerate
24 of the many languages spoken by the API community.
25 I'm 30 years old, 13 years outside of what would

1
2 be considered a youth. My experiences as a
3 teenager in the early and mid-1990s were very
4 different from the reality of gay youth today, the
5 youth that we serve. Some things may be the same,
6 however. For example, I never felt that I had a
7 safe space to talk about my sexuality in my
8 catholic high school. I didn't feel like I had
9 access to gay affirming sexual health information.
10 I also didn't feel that I could be completely open
11 with my family doctor. These issues stayed with
12 me even to this day. I often refer to myself as a
13 recovering catholic. People often say that coming
14 out is a gradual process for youth--you tell
15 different people at different points in time in a
16 variety of different contexts. Flash forward to
17 2009, focus group after focus group, counseling
18 session after counseling session, our gay Asian
19 youth are saying the same things that I was
20 thinking when I graduated high school in '97.
21 Now, if we're tired, angry, sad, lonely, all our
22 friends will be able to read about it on our
23 Twitter updates. The internet has become the
24 primary tool for driving young gay people out of
25 isolation. They can find other gay men online and

1
2 communicate with them. They can flirt, update,
3 poke, instant message, email, webcam, Skype,
4 Twitter, send roses, send kisses, all from the
5 privacy of their bedrooms. And the next day, they
6 can go to school and not even identify as gay.
7 Thanks to the persistent activism of my colleague,
8 Suki Ports [phonetic], Therese Rodriguez and John
9 Chin, we have been able to reach API gay men, 18
10 years and older, by creating safe spaces, offering
11 gay affirming services, and educating funders
12 about the unique cultural and linguistic of APIs.
13 Now that the platform has been set, we are faced
14 with the challenge of moving forward, of adapting
15 what my colleagues created and implemented 20
16 years ago, in order to reach this next generation
17 of gay young men. The next level of HIV
18 prevention must be cognizant of the fact that the
19 communication has changed, and for young gay men,
20 the change is in their favor. It is also in our
21 favor. The day of safe sex workshops in schools
22 or CBOs that saw zero to little attendance, can be
23 replaced with a private workshop at home. The
24 young person can get the same information without
25 the stigma of known association with it. We are

1
2 ready to deliver the same messages but lack a
3 venue. The internet is a venue that we need to
4 deliver these messages. And the Council must take
5 a leadership role in guiding funding and making
6 policy changes to foster this. APICHA serves a
7 diverse community that speaks many different
8 languages, so we ask that any plans to implement
9 internet based interventions include materials
10 that reflect the cultural diversity of our young
11 gay, New York City residents. Without special
12 attention given to online interventions, social
13 marketing, and innovative ways of reaching the
14 next generation of YMSM, we risk ignoring these
15 new safe spaces, or cyberspace. Online social
16 networking and hookup sites are their own
17 community, and within these websites, you have a
18 captive audience. Gay Asian youth are huge
19 consumers of online resources; however, there is
20 very little to no representation of APIs in HIV
21 related social marketing, thus perpetuating the
22 age old model minority myth that they are not at
23 risk. The significant increase in new HIV
24 infections among API YMSM in New York City cannot
25 be ignored. Prevention efforts need to be

1 supported financially and with appropriate policy
2 changes. Strategies need to be technologically
3 age and culturally appropriate in order to be
4 effective. New York City has the opportunity to
5 be a leader in implementing innovative social
6 marketing strategies. The interventions have
7 already been completed. They've been tested and
8 proven to be effective. Now we just need your
9 help in delivering them.
10

11 Good afternoon, New York City
12 Council Members. My name is Jacobi Johnson, and
13 I'm a program director in the Black Men's
14 Initiative at Harlem United, a 20 year old
15 multiservice AIDS organization servicing the
16 residents of upper Manhattan and South Bronx. We
17 provide healthcare, supportive housing and HIV
18 prevention and support services. Our prevention
19 division targets various high risk and vulnerable
20 groups within our diverse neighborhoods, with a
21 special emphasis on young men of color who have
22 sex with men, who I refer to in my testimony as
23 MSM. As I'm sure you're aware, young MSM are the
24 only CDC designated category of high risk persons
25 that have experienced an explosion of new HIV

1
2 infections over the last few years. HIV is the,
3 is only one of several life threatening epidemics
4 and oppressive forces that disproportionately
5 affect MSM of color. On top of the normative
6 adolescent development challenges, depression and
7 severe mental illness--neural, development or
8 psychiatric--violence, isolation, drug use and
9 homelessness have a higher prevalence rate among
10 MSM than among men in general. These issues
11 converge and create a syndemic where each one
12 amplifies the others' negative effects, increasing
13 HIV risk. While MSM have to address all of these
14 issues at the same time, they're not free to
15 protect themselves effectively from HIV.

16 Therefore, our strategies have to address all
17 these issues and we have to work on the individual
18 community and structural levels simultaneously for
19 maximum effect. On the individual level, we need
20 to encourage young MSM to analyze their sexual
21 risk, and set risk reduction goals. We need to
22 help build their self-esteem and self-worth, by
23 helping them achieve their personal goals for
24 mental health, employment and social
25 relationships. On the interpersonal level, we

1
2 need to encourage young MSM of color to negotiate
3 prevention responsibility for themselves and their
4 sex partners. We still employ the use, the "use
5 the condom every time" message for people who have
6 to plan their risk reduction over a lifetime.

7 This is inadequate in a high prevalence community,
8 in the age of effective HIV treatment. Sexually

9 active MSM need to plan long term risk reduction

10 strategies, where risk is relative depending on

11 sex partner, HIV status and sex behavior. Such

12 strategies can and should include sero-sorting,

13 using HIV treatment to reduce viral load, and

14 broader expansion of post-exposure prophylaxis,

15 PEP, and other risk reduction strategies, known to

16 gay men that may make people feel a bit

17 uncomfortable. Examples, endorsing oral sex as an

18 alternative, or using female sex, female condoms

19 for anal sex, or separating party and play, or

20 exacerbating excessive drug use while having sex.

21 While not 100 percent foolproof, relative risk

22 reduction allows MSM to make informed decisions

23 every time they have sex for their entire lives.

24 This can become a community norm that reduces HIV

25 stigma, as we normalize various relative risk

1
2 reduction strategies. To date, nearly all HIV
3 prevention efforts have been devoted to reducing
4 risk at the individual level, with less attention
5 being devoted to reducing community viral load
6 among MSM. Heterosexual couples don't use condoms
7 more than gay people do. They just don't have as
8 much HIV in their sexual networks as MSM do. On a
9 community level, we can have a greater impact on
10 HIV transmission if we can provide HIV and STI
11 testing services every six months and link HIV and
12 STI positive people to care immediately.

13 Recruitment for routine HIV and STI testing need
14 to expand throughout the internet, clubs and
15 social spaces, and via social network strategies.
16 The New York City Council can require all medical
17 students working in HHC settings to receive
18 training in LGBT health and stigma reduction, so
19 that MSM of color are treated with dignity and
20 respect when they access HIV care. When more HIV
21 positive men know their status, gain access to
22 quality healthcare, and start treatment earlier,
23 we will see a lower community viral load, and drop
24 in new HIV infections. Finally, prevention
25 strategies for gay men must be tailored to the

1
2 diverse communities of MSM that exist in New York
3 City; tailored to a group or network socioeconomic
4 status, housing status, race, sexual identity,
5 education and mental health, all in the context of
6 social stigma, racism, homelessness, homophobia
7 and violence. Tailoring programs to the
8 demographics of MSM and city neighborhoods would
9 allow us to create a cutting edge, street smart
10 quality program, that addresses the specific
11 prevention needs of our local MSM. Harlem United
12 is committed to working with MSM and their allies
13 to address the various levels of problems that
14 allow HIV to flourish. Our Black Men's Initiative
15 has created a safe space we call Home,
16 specifically for young MSM in Central Harlem and
17 South Bronx. We have reached over 3,000 MSM of
18 color during outreach events, provided 866 HIV
19 tests, and identified 45 HIV positive men. Of
20 these, we've recruited into our safe space in
21 Harlem, called Home, we provided a total of 110
22 support and education groups with an average
23 attendance of twelve to 15 young MSM per group.
24 We delivered several CDC interventions, we've
25 completed eleven cycles of popular opinion leader

1
2 on the internet, five cycles of "Many Men, Many
3 Voices," and three cycles of the Community Promise
4 Intervention. All of these services are
5 coordinated in a continuum so that young men
6 receive individual counseling and psychotherapy,
7 participation in group training and support, and
8 give back to their community as peer advocates and
9 educators. By building this continuum, we develop
10 a healthy and healing community where young MSM
11 also have access to housing, medical care and case
12 management services. Thank you for your time.

13 COUNCIL MEMBER STEWART: Before you
14 continue, is Steve Gordon--could you join the
15 panel, please? [pause]

16 Good afternoon. My name is Craig
17 Cobb, and I am the Acting Executive Director for
18 the National AIDS Education and Services for
19 Minorities, affectionately called NAESM. NAESM is
20 a 20 year old organization that was founded to
21 serve black gay men at risk and infected for HIV
22 and AIDS in Atlanta, Georgia. And you may ask,
23 what are we doing in New York? NAESM established
24 itself in New York City in June of 2009 as a
25 result of the implosion, or the closing or

1
2 collapsing of two organizations specifically
3 funded to serve black gay men. I speak to you in
4 that context. When I was 19 years old, I was
5 pulled into an office and was told that I was HIV
6 positive, and that I had five years to live. I
7 sit before you at the age of 40, half bald and
8 half gray, never thinking that I would actually
9 look in the mirror and see that. What sustained
10 me was the breakdown and conflict of recognizing
11 my status and then realizing that I am a part of a
12 larger community that actually loves and embraces
13 me. And that is a gay community. There is a
14 clear distinction that I want to make. As
15 excellent as the term MSM is, that encompasses all
16 of the behavior, there is great value in
17 recognizing the power of the word gay. And for
18 youth who are at risk to be able to look in the
19 mirror and confront themselves as gay. When we
20 use the term MSM, yes we speak to a behavior, but
21 when we use the term gay, we actually speak of a
22 culture. And in any culture that you think of, if
23 you learn to love yourself in the context of that
24 culture, you have a greater opportunity for
25 affluent life. If you live an oppressed identity,

1 denying that gay identity, then you will put
2 yourself at more risk for a variety of issues.
3 But in the context of homosexual behavior, we're
4 talking about anal and receptive and insertive
5 sex, it is a sheer path to death. So there are
6 three recommendations at its end. I recommend
7 increasing basic HIV prevention tactics. In the
8 last ten years, the United States has somewhat
9 lost that. We used to just hand out condoms, drag
10 queens in gay clubs, colored outfits and just
11 condoms amiss, condoms everywhere. Now, the CDC
12 no longer directly funds organizations that can
13 actually do that. We've got to watch our
14 language, we've got to watch the images, and
15 respectfully, while some of them were a little
16 risqué, they were effective. The second component
17 is the fluent availability of prevention materials
18 for free. Listen, go to a bookstore, pay for a
19 condom; go to a park, any park in New York City,
20 I'll put it on the table, any park in New York
21 City, the larger parks--Brooklyn's Prospect Park,
22 Harlem's St. Nicholas Park--go in the middle of
23 the night, actually you can go 24 hours a day,
24 seven days a week, you will find a gay men in

1
2 there seeking sex. And in the ten years that I
3 have been in New York City, walking up and down
4 those stairs, to and from the colleges where I
5 teach public speaking, I have to say that in the
6 ten years I've lived in New York, I've only seen
7 one person ever doing outreach in a park. And so
8 if I use drugs, smoke weed, let's say, maybe
9 occasionally do whatever kind of drug, and go to,
10 and live a cloaked existence and go to a park to
11 engage in homosexual activities, and then I am
12 there after 10:00 p.m., I am arrested or possibly
13 detained, if I have drugs in my possession I am
14 arrested, and so there begins the cycle that we
15 spoke of earlier. We now have incarceration and
16 we have homosexuality, and we have no condoms, and
17 we have a perpetuated cycle of HIV risk. The
18 third part that I think New York City must look
19 at, and I think that many of the regulations
20 around pharmaceutical, the pharmaceutical
21 industry, have somewhat changed. But in the last
22 ten years, we have glorified living with HIV and
23 AIDS. Some of the same AIDS activists who have
24 promoted prevention and treatment have actually,
25 have also starred in glossy campaigns promoting

1 climbing mountains and what, what great, what a
2 great lifestyle it is to live with HIV and AIDS.
3 It's not a happy story to live with HIV and AIDS,
4 with or without medication, it's not. And so at
5 its end, if we teach youth to love and respect
6 themselves, and the community that they represent,
7 specifically being gay, or bisexual, we can
8 encourage and then stem, and stem the tide of HIV
9 and AIDS. So what I'm presenting is not
10 complicated. What I'm presenting at the age of
11 40, is what we talked about 20 years ago. And I
12 think there needs to be a resurgence of very basic
13 prevention messages. Thank you.

14
15 STEVEN GORDON: Hello, Council
16 Members, everyone in the audience. We've heard a
17 lot of really great, eloquent speakers. My name's
18 Steven Gordon, I direct the HIV services at the
19 Ali Forney Center, which the Commissioner briefly
20 spoke about in her report. The Ali Forney Center
21 is a service provider for homeless LGBT youth. We
22 provide housing, social services, medical case
23 management outreach, housing, like I said, HIV
24 testing, medical and psychiatric services. With
25 that being said, I'm here to actually speak about

1
2 how this housing component is actually directed,
3 correlated to the HIV risk factors that these
4 youth are facing. So there is a severe lack of
5 housing for our LGBT youth in the city. Many of
6 the city's youth are forced out of their homes
7 because their families don't appreciate their
8 sexual orientation or gender identity. Last year,
9 the National Gay and Lesbian Taskforce published a
10 report on LGBT youth. One of the first things the
11 report stated was that our country can't even
12 begin to deal with LGBT health until we talk about
13 stable housing for our population. Every night in
14 the city, over 100, over 1,000 LGBT youth do not
15 have a place to sleep. There are less than 100
16 beds for LGBT homeless youth to sleep in. This
17 shows a huge disparity of care. Because of this,
18 many of these men to turn to sex as a mean of
19 survival, sex work, rather. The Ali Forney Center
20 tests 30 young people every month; of that, ten
21 percent of those young people will test positive.
22 35 percent of our clientele have HIV. One out of
23 this 35 percent is a biological woman; the rest
24 are MSM. This also says something about this
25 disparity of care, the need for prevention. Care

1
2 for the homeless, a huge homeless service agency
3 that provides my agency with the HIV testing,
4 tests nine sites in New York City. They told me
5 last year that out of their nine sites, the site
6 that I run has the most sero-conversions of the
7 United States all put together. That is huge.
8 What does this tell us? This tells us that we
9 need to think outside the box and stop thinking of
10 testing as a way to treat. My agency's
11 recommendation is to actually put prevention back
12 on the table, to give agencies that have the
13 cultural competency, the capacity to actually
14 deliver the prevention services. What else, might
15 we ask? How about mental health services?
16 There's a severe lack of mental health services
17 for this population. Because of that, a lot of
18 this population are facing depression, substance
19 use. We need to be able to attack these issues
20 from a cultural competence standpoint. And last,
21 we would like to say action. We were, a lot of us
22 in this room were here about a year-and-a-half
23 ago, having what seemed to be a mirrored
24 conversation. It would be nice that in the next
25 year-and-a-half, we can actually see, see some of

1
2 this in the community on the streets, have
3 prevention moneys to actually take to our youth,
4 and, and say that instead of Ali Forney having 35
5 percent of their youth being HIV positive, maybe
6 next year it can be 25. So thank you for your
7 time. [applause]

8 COUNCIL MEMBER STEWART: I have one
9 question that I would like, if you can answer it,
10 it would help us in terms of formulating laws and
11 policy within the City. You heard the testimony
12 of the young man who was in the last panel. I
13 would like to know, the older, affluent,
14 financially sound person who might be, you know,
15 have it all together, how could we prevent such a
16 person from preying on a younger person, you know,
17 who may not be aware, who might be naïve, and all
18 of that. How can, what can we do to prevent that?

19 STEVEN GORDON: I'm not certain
20 that you could prevent an old per--and older
21 person from doing that. What we could prevent is
22 from the younger person to respond, responding to
23 it. I think we have, we would have better
24 success, and again as many of us have said in
25 different terms, helping a youth respect his own

1
2 identity as a gay man, and be a part of a larger
3 community that loves and supports him. Now that
4 somewhat Hallmark conversation and Hallmark
5 language, but at its root we're talking about
6 funding agencies that serve black gay men, more so
7 than we are talking about funding programs that
8 serve black gay men. Large agencies can have a
9 small program to serve--I'm sorry, to serve gay
10 men of any color. But it is, it is more fluent, I
11 believe, I serve agencies that are completely
12 committed to that. So that when youth are growing
13 and matriculating through the City, there is a
14 larger community norm that says, "Hey, you're a
15 part of this." And it's the social cognitive
16 theory in some varying capacity. And the CDC has
17 promoted this for years. So, I'm not, I'm not
18 certain that we can actually stop that man from
19 preying on young kids as much as we are, ought,
20 inclined to help that young man say, "I don't have
21 to respond to that."

22 COUNCIL MEMBER STEWART: I

23 basically understand what you're saying, but if
24 you remember, the gentleman said he wasn't aware
25 that he was inclined to be gay. He was not aware

1
2 until he was introduced and he was, he was given
3 all these gifts and all these things. He wasn't
4 aware. So, on, and he learned that after he was
5 approached. He learned after he was, he learned
6 all these things after he has been infected. My
7 point is basically how can we say, "Well, listen,"
8 you know, before that young man or that young
9 child, whatever, is caught up in something like
10 that, they need to know. Even if he's gay, even
11 if he's inclined to be gay, whatever, he needs to
12 know what he's exposed to. And I want to know
13 that the older, affluent person who may have all
14 the wherewithal to do, to give all these things,
15 how can we prevent him from using his influence
16 and all of that, to really get that young person.
17 Because if he had known, if that young man had
18 known what is entailed from, I don't think he
19 would've been infected at this time.

20 STEVEN GORDON: You are, we are
21 basically saying the same thing: if that young
22 man would have known. Well, how do we make that
23 young man know? we have a drop-in center that
24 identifies, that helps young gay and bisexual men.
25 We have programs in schools, or we establish

1
2 programs in schools, that can identify. We as, we
3 as responsible, logical and sober adults, come on.
4 We know when gay is gay. Stop. We pretty much
5 know when gay is gay with the youth. And he may
6 not have known as a youth, but some adult knew.
7 And the wrong adult knew and took advantage of it.
8 If the right adult knew, and said, "Come here,
9 son, I got some things to show you, I have been
10 where you're at, you haven't been where I'm at."
11 Then maybe we could've rectified, we could've
12 prevented what we heard today. And so I think
13 that in the, in the patchwork if you will of all
14 of the things that you have heard here, we're
15 basically saying that. We need to focus on
16 community norms that help youth to say, "I think
17 that's me and I think I'm okay with it."

18 COUNCIL MEMBER STEWART: So, in
19 other words, you're saying we should spend more
20 time in educating the kids in the school about
21 what, what gay or--that's - -

22 STEVEN GORDON: I don't know if I'm
23 saying educating them on what gay is, but
24 educating them on the resources and empowering and
25 funding the resources in communities that say, "It

1 is okay, and it is appropriate, and it, there is
2 a, there is a fluent life ahead of you, if you're
3 gay, and you are attracted to the same sex."
4 instead of not, rather in combination with doing
5 work for MSMs, because the MSM concept allows for
6 an amorphous identity. It allows for people to
7 engage in the behavior and then say, "Hey, that
8 ain't me," when you go into a, or not even go into
9 a gay club, and see the messages and see the
10 great, the glossy posters that clearly identify
11 gay men. So, I'm just saying that in a community
12 environment--schools, bookstores, where have you--
13 there need to be resources where youth can be, can
14 learn that it is okay to be gay. I think there's
15 a--

17 COUNCIL MEMBER STEWART: But I
18 agree, it's, it's, you--it's good to learn that
19 it's okay to be gay, but I think there needs to be
20 some sort of education to, to say, "Well, listen,
21 being gay, you, the lifestyle of most gay people,
22 you got to realize that there are risks that are
23 involved, and we have to teach and help those
24 young people understand that."

25 STEVEN GORDON: Well, I apologize,

1
2 sir, I, I meant that in coordination with basic--
3 From my perspective, as a black gay man, who has
4 been infected for 20 years, HIV prevention is
5 assumed in that statement. There is no
6 separating, respectfully, my left from my right.
7 I will, I will not fill in the blank. But the HIV
8 prevention and living a gay identity must go hand-
9 in-hand, there is no separation now. Not in the
10 worst epidemic that the world has ever known. So
11 when I engage a youth and tell him that it's okay
12 to be gay, I also tell him how to say, how to stay
13 okay being gay, and that is where HIV prevention
14 becomes prevalent. Sorry.

15 COUNCIL MEMBER STEWART: Anybody
16 else have any answers?

17 JACOBI JOHNSON: Yeah, I just,
18 'cause we're referencing the testimony of the
19 gentleman that spoke before, and it was a really--

20 COUNCIL MEMBER STEWART: Pull the
21 mic a little closer, please.

22 JACOBI JOHNSON: It kind, it's, it
23 was a really touching like sort of case study
24 where you dissect the pieces of it and you talk
25 about what was going on with that individual.

1
2 First and foremost, the thing that comes to mind
3 is that he was an adolescent at that time. So
4 there's, there's the adolescent development piece
5 that you have to really kind of work with these
6 individuals and separate that from whether the
7 person is gay, straight, whatever, this is, this
8 had to do with someone who was transitioning into
9 adulthood. And there's a lot of moving pieces
10 there that you should work with. And to kind of
11 say, how do we stop a predator from preying on a
12 young adult or an adolescent, is, it's a separate
13 issue altogether, to talk about someone's sexual
14 identity. So, I just wanted to kind of clarify
15 those, those kind of two, kind of pieces that
16 we're moving, in my head I'm saying, "This is a
17 young person who was preyed on by an adult." It's
18 illegal, you know, a minor that's twelve years old
19 having sex with someone who's in their 30s or 40s,
20 that's just an, it's just illegal. So, I mean,
21 what you need to do is provide supportive services
22 for, for young folks who are going through these
23 changes, and not understanding how it affects
24 them, you know, you know, there's the hormonal
25 change, there's, they're coming into their, into

1
2 their own, when it comes to their sexuality, and
3 that's more the focus. So, it's, it's probably an
4 empowerment product that you should be looking at
5 for adolescents. I don't think it should be about
6 whether the person is gay, or MSM or whatever
7 terms we decide to coin or call it today. It
8 really is about the development of that individual
9 and how they transition into adulthood, and we
10 support them and give them some tools that show
11 them that they can be empowered around making
12 those kind of decisions. But it's really just a
13 funky stage in life, when you're that, when that,
14 when you're that young, you don't really know, you
15 know, you're not mature enough to make those kind
16 of decisions. So, you need the support system
17 there. But I don't know if it's so much about the
18 person being gay.

19 COUNCIL MEMBER STEWART: Alright,
20 there's only one issue I, I had in mind that I, I-
21 -that you raised earlier, about trying to separate
22 the term gay from MSM. And to me, I think if you
23 just say "gay," you're really leaving out a lot
24 of, a lot of folks. Because a person can be gay,
25 and he establishes and he lets know, and he's not

1
2 necessarily proud of it, but at least he is, he
3 identify himself as being one who is gay and he's,
4 feels comfortable with it. But there are folks
5 who, you know, behave and, and have behaviors
6 that, you know, really not to community standards
7 and all of that, and they do things like having
8 sex, men having sex with men, but they not only
9 have sex with men, but they have sex with women,
10 and they, you know, or even those who may have
11 behavior that are not even human, that you can
12 think about. And they do these things because
13 they want to feel good, whatever, they take drugs
14 and all of that. So, I think the, the issue here,
15 although I agree with some of the things that you
16 said, I think men who have sex with men, it's a
17 much more, deeper understanding that we should
18 have than, than just saying "gay."

19 CRAIG COBB: If I may--

20 COUNCIL MEMBER STEWART: Because
21 being gay, it's, to me, a person could be gay and
22 not having sex.

23 CRAIG COBB: Right. I agree with
24 you.

25 COUNCIL MEMBER STEWART: And, and

1
2 but we want to make sure that we are preventing
3 the spread of HIV and AIDS, and also from, you
4 know, doing things that are not being something
5 that you will change the younger person, or have
6 an influence on the younger person. Alright?

7 CRAIG COBB: I agree with you, I
8 just--

9 JACOBI JOHNSON: We agree. Yeah,
10 we agree.

11 CRAIG COBB: We agree, I think we
12 just were saying that over the last ten years, the
13 term MSM has become so overwhelming, and
14 effective, that we, we have lost some semblance of
15 what it is to be simply gay. And that's all I was
16 saying. I agree, I agree with what you said.

17 JACOBI JOHNSON: I agree with - -

18 COUNCIL MEMBER STEWART: I want to
19 thank you guys for your testimony. I, every day
20 I, I learn a lot more of what's happening, and I
21 want to thank you for bringing such insight to
22 this Committee. Thank you.

23 JACOBI JOHNSON: Thank you so much.

24 CRAIG COBB: Thanks.

25 COUNCIL MEMBER STEWART: This

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hearing is closed. [gavel]

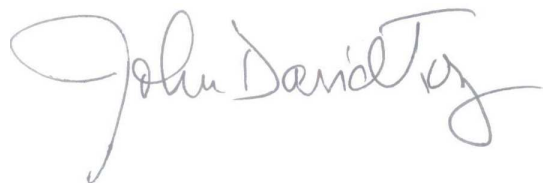
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[silence until end]

4

C E R T I F I C A T E

I, JOHN DAVID TONG certify that the foregoing transcript is a true and accurate record of the proceedings. I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

A handwritten signature in cursive script that reads "John David Tong". The signature is written in dark ink and is positioned above a horizontal line.

Signature_____

Date October 1, 2009