NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Oxiris Barbot, MD
Commissioner

The DOHMH held a Community Engagement Group (CEG) Request for Proposal (RFP) Listening Session on October 12, 2018 to obtain community feedback and input to inform the development of a future RFP. In compliance with applicable laws and rules attached are the following documents:

- **Attachment A:** A transcript of the ----GEG RFP Listening Session (transcript
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NEW YORK CITY

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CEG RFP LISTENING SESSION

161 East 110th Street
October 12, 2018

Transcribed by
Kimberly LoNigro, Court Reporter

A P P E A R A N C E S:

Richard Anthony, Department of Health and Mental Hygiene

Alzen Whitten, Bureau of Maternal, Infant and Reproductive Health

Deborah Kaplan, Bureau of Maternal, Infant and Reproductive Health

Barbara Hart, Bronx Community College

Lynn Roberts, CUNY School of Public Health

Jacqueline Q. Lugo, Bureau of Maternal, Infant and Reproductive Health, Sexual and Reproductive Health Unit

Allyna Steinberg, Bureau of Maternal, Infant and Reproductive Health

Elaine Armstrong, Family and Child Health

Judi Soehren, Department of Health and Mental Hygiene

Margaret Tulli, Department of Health and Mental Hygiene

Odette Harper, Department of Health and Mental Hygiene

NOT PRESENT:

Lindsay Dubois, Community Healthcare Network

Heather Daley, Diaspora Community Services

Darly Coupet, Gwookle, LLC

Chiwoniso Kaitano, Ifetayo

Uwingablye Cunningham, Ifetayo

Leeann Rizk, NY Presbyterian

Patreinnah Ascost-Pelle, PR City

MR. ANTHONY: Good morning, everyone. Thank you for coming out today. Please be aware this session is being recorded and the minutes will be transcribed and posted on our website.

This session is an opportunity for us to listen to members of the community, to obtain your suggestions regarding any potential requests for proposal for our community engagement stake holder, coordinator, for Sexual and Reproductive Justice Community Engagement Group.

Please note that all future projects are contingent upon availability of funding and they are subject to change.

Due to time restraints, we are going to limit these questions to 15 minutes, and there's a possibility to add questions at the end, if we have extra time.

Should there be additional questions outside of the scope of today's session, please be aware you are going to have the opportunity to submit additional questions after we do release our (inaudible). Please also note, you have the opportunity to provide written

questions at the end of the session to the e-mail at srj@health.nyc.gov.

Now I will transition to Alzen -- Deborah.

I am Richard. I'm a contract manager for Family & Child Health, and we also ask that you state your name when you're talking.

Thank you.

MS. KAPLAN: Good morning. I'm Deb Kaplan, the Assistant Commissioner for the Bureau of Maternal, Infant and Reproductive Health.

I just wanted to echo Richard's words. Thank you for coming and also noting that this listening session came about because of really an ask -- and a strong ask -- from community members, particularly those in the Sexual and Reproductive Justice Community Engagement Group who felt strongly. And we agree that it's important for the City to get meaningful input from community members on how the City and, in this case, the New York City Health departments spend our funds before we issue an RFP or any other kind of executive procurement.

Many of our community partners have voiced their concern that community members are not

always provided with this opportunity, and we heard you and agree that community input is essential for this work, and that is the express reason that we're holding this listening session, including opportunities for people to be here in person, to submit written comments. And anyone who was not able to attend will also be able to submit written comments and will be able to see the full documentation of what transpires today.

And with that, I'm going to turn it over to Alzen Whitten who's the Director of the Sexual Reproductive Unit at the Bureau of Maternal, Infant and Reproductive Health at the New York City Department of Health and Mental Hygiene.

MS. WHITTEN: Hi. Good morning, everyone. We are happy to be here today to have this listening session which responds to a request from CEG to have input into future contracts with the CEG consultants. To those new to CEG and SRJ, Sexual and Reproductive Justice, I will provide a good full overview.

The Sexual and Reproductive Justice framework is in line with the Department of

Health's focus on undoing racism's inequities and promoting health equity. SRJ exists when all people have the power and resources to make healthy decisions about their bodies, sexuality, and reproduction. That means that every person has the right to choose to have or not to have children, choose the conditions under which to give birth or create a family, care for their children with the necessary social support in a safe and healthy environment, control their own bodies and self-expressions free from any form of sexual or reproductive oppression.

The term reproductive justice was coined by a group of black women in 1994. SRJ is an ongoing organizing framework that is based on an internationally accepted human rights doctrine and utilizes strategies that ensure that the people who are facing the most significant social, economic, and health challenges have the power and resources to influence policy within the institutions that affects their lives. These strategies include the six listed here where you can learn more about by searching SRJ on the New York City

Health Department's website.

The SRJ CEG was convened by the Department of Health in July 2015 as a vehicle for ongoing community engagement in developing public awareness campaigns, as part of a four -- five-year Sexual Reproductive Health initiative that ends in June two thousand -- June 30, 2019. The health department and other CEG members are seeking funding to continue the efforts of the group.

The group is comprised of community members, activists, academic and nonprofit organizations working in partnership with the New York City Health Department. This collective approach is intended to give community voice in campaign development and implementation to ensure campaigns are respectful, culturally rounded, and have a wider reach and have more profound impact on sexual and reproductive health outcomes.

Informed by the SRJ framework, the CEG uses a community-based participatory approach involving community members most affected by the sexual and reproductive health injustices. These communities at the center of their work

are listed on the slide and include, low income people, people of color, lesbian, gay, bisexual, transgender, queer, intersex, asexual Latinx, gender nonconforming, immigrant and other non-US seeking, pregnant teens or teen parents, elderly, victims/survivors of sexual assault, human trafficking and domestic violence, people in the commercial sex industry and people who are differently abled.

In order to develop a campaign, they conducted community gatherings in 2017 to identify the most pressing SRJ issues in the community. They then developed proposals and the top five things have emerged. Then they voted. Each organization had one vote, including the health department. This resulted in a Birth Justice campaign that involved engaging community as Birth Justice Defenders, engaging Birth Justice Champion Providers, conducting community events and hospital rounds, as well as creation of educational materials.

Building on the work of past CEG consultants that have helped shape the CEG model of shared leadership and facilitate CEG

meetings and processes, this is a list of potential services that may be included in a possible future solicitation.

UNIDENTIFIED SPEAKER: -- it's not on the screen.

MS. WHITTEN: First, formalize community engagement model of shared leadership and decision making by DOH and community participants in CEG and assuring that the CEG serves the best interest of New Yorkers and it's assessable to centered communities.

Second, hold all CEG members to shared leadership and decision-making processes, including DOH and community members, serving as a moderator as needed, including being a mediator between the CEG community members, including the Department of Health, to continue to establish trust and transparency.

The third thing we're looking for is to convene annual strategic planning retreats and updating of the CEG model as necessary and convene CEG meetings, including facilitating and producing minutes.

Fourth, lead CEG member engagement work groups, including conducting member outreach or

organization retention activities.

Fifth, managing or leading CEG ad hoc committees. Sixth, managing CEG's speaker's group, including creating and maintaining key documents such as one pager's, presentations and talking points.

Seventh, subcontract with and/or work closely with other CEG consultants.

Lastly, participate in CEG monitoring and evaluation activities.

I'll now pass it over to Richard.

MR. ANTHONY: Thank you.

We'll open it up to our questions now. So if would you please state your name before you respond to it. Question one will have fifteen minutes.

What experience and qualifications do you think are necessary for the contractor?

UNIDENTIFIED SPEAKER: So you just want people to raise their hands?

MR. ANTHONY: Yeah.

MS. HART: Say my name?

MR. ANTHONY: Yeah.

MS. HART: Good morning. (Inaudible). So I'm Barbara Hart, but everyone knows me as

Bobby Hart.

So experience and qualifications we think are necessary. Excellent interpersonal skills are required. Flexibility in terms of being able to adjust if something comes up, because something always comes up in the Department of Health. Knowledge of contracts, how to write them. Knowledge of public health, but more specifically, knowledge and past experience with Maternal and Infant Health, Sexual Reproductive Justice, women's justice, women's rights, and violence against women. All of that needs to be some basic knowledge and be experienced in those areas.

MS. ROBERTS: Good morning. My name is Lynn Roberts. I'm with the CUNY Graduate School Public Health and Policy.

I would like the contractor to have past experience working with government institutions, in addition to working with community-based organizations. Sometimes the skill set is different for both of them -- for each. And to also be -- have strong group facilitation skills. Being able to build consensus among disparate movements, diverse

groups, and to manage -- manage conflicts creatively and a good sense of, as Bobby said, the SRJ framework, but in (inaudible) matter, broader social justice awareness or human rights framework. Someone who knows the communities of New York City and has ideas for how to engage folks across the broad diversity of communities.

So, (inaudible) mentioning candidates' educational credentials, but even it would be great if the person has a master's in public health to help with administration, something where they would learn the skills of dealing with the public in general. And it would also be helpful if the person is a person of color, because the overall majority of the people they're going to be working with are going to be people of color.

In terms of the MPH degree, I most specifically would favor someone with background in the community health aspects of public health. Models of community-based participatory research would be helpful since they interface with us in evaluation activities.

But I think there could be comparable degrees. Someone who is grounded in, you know, applied social work might also bring a set of skills that would be transferable to this project, and I wouldn't want to limit them with the MPH degree, but it would certainly be a favored qualification. And as I said, with frameworks, I guess, grounded in, if not in Sexual Reproductive Justice, perhaps black feminism, human rights, other related members that are very pertinent to this work.

I can't think of anything else in terms of specific qualifications. Time's up and -- sure.

UNIDENTIFIED SPEAKER: So it would also be helpful if the person had experience within advocacy. Advocating in the community based on anything in health, you know. So it could be Maternal and Infant Health. It could be HIV and AIDS. But the advantage of having some skills or experience with speaking to legislators, speaking to people to advocate for the community in terms of policies, public policies.

MR. ANTHONY: Thank you. We'll transition

to the next question.

(Conversation takes place outside of microphone recording.)

UNIDENTIFIED SPEAKER: All right. Many of us take it for granted that they should have strong writing skills and oral skills as well. Because the facilitation requires a lot of that, that there will be a lot of report documentation.

Quantitative skills, mostly around being able to assemble and being able to, you know, think data, generate data, to pass through some small spreadsheet type, you know, analyses for the purposes of coordinating (inaudible).

UNIDENTIFIED SPEAKER: I have a question. Can I ask a question or no?

MR. ANTHONY: (Inaudible.)

UNIDENTIFIED SPEAKER: Okay. Yeah.

MR. ANTHONY: So question number two.

What responsibilities do you think a contractor should have?

UNIDENTIFIED SPEAKER: In addition to what was shown earlier?

MR. ANTHONY: Yes.

UNIDENTIFIED SPEAKER: Ensuring that the

CEG of the community information -- process goes smoothly. That there's good communication between agency, staff, and community partners, members. Being able to communicate well with the different constituent groups in a timely fashion. Organizing the calendar set groups or core groups. Shaping the (inaudible) purpose looking to process and (inaudible) future strategic planning (inaudible) drawing out the groups (inaudible) democratic process.

I could come up with others, but that's off the top -- (inaudible).

MS. HART: Okay. So Bobby Hart, again.

The person should be responsible for being the liaison between the community at large, the Community Engagement Group and members of it, and the Department of Health. It's still our voice independently, so they can share their thoughts on the process.

I think the person should also be responsible for navigating through the community, not just sitting behind a desk and sending out e-mails and making phone calls. They need to get out in the field and meet various people in the community, because you

don't learn about communities sitting at a desk.

MS. ROBERTS: Lynn Roberts again.

I think also the -- the role of the contractor or primary responsibility is to curate the work plan, again, through this engaged process, but being able to ensure that, you know, the great meaningful objectives, (inaudible) objectives and being able to keep us on -- on track, on task, and, I mean, also setting reasonable goals that are achievable.

But I think it's a responsibility for this person to also help to shape and interact with other units of the Department of Health so that we can share this model or this approach more widely. So being able to document that well and communicate about it to the broader communities of New York. It's a tall order. it is. It is a tall order.

But I'm going to go back to the summary (inaudible) liaison and when I was saying, being a liaison, you know, with the Department of Health is also (inaudible). So I'm basically thinking that (inaudible). I'm saying it over -- that prevents that because we

discovered over these years that the SRJ CEG is unique.

I learned that there are other CEGs within the Department of Health, that they don't speak to one another, and what we've done here with SRJ is truly unique.

So the responsibility of this person coming in would be to speak to the other CEGs and find out what's going on and how we interconnect together and advocate as one body when hearing our community. Because my whole purpose in being in public health is to help heal our community. Thank you.

MR. ANTHONY: So our next question will be what type of -- what type and frequency of reporting do you think contracts should provide?

UNIDENTIFIED SPEAKER: No. Cause I'm still trying to figure out what they're asking.

Do you understand the question?

UNIDENTIFIED SPEAKER: Well, in terms of type -- well, first of all, it should be bidirectional. So it should be both reporting to the Department of Health, but also to the community about the activities. I think

there's a system pretty well established for doing that, for monitoring it at least.

I guess their report would be how well they have facilitated our process, how well they have engaged, and how well they have ensured that the goal was set by the CEG.

Frequency? Depending on how the structure and process of the CEG might evolve by the time this (inaudible) materializes could depend on how well or how frequently the CEG determines the frequency or they're even meeting.

So before I mentioned quarterly or annually, depending on some of those factors. I don't -- I have a strong opinion about that. I think that's more to be negotiated at the time of selection for hire. But I have a strong opinion about that.

MS. HART: Bobby Hart again. I guess the type is what's confusing me or where I'm having a thing about it, cause in terms of types, they should be reporting the outcomes of their meetings, not just we had another CEG meeting the other day and 36 people came. I would hope to hear we had a CEG meeting, we discussed this, these things were brought up and there

were wildly discussions when someone spoke. So I want to hear about quality of the meetings. What came out of them, what was said in them.

So, again, that word "type" is, you know, is kind of stopping me. But types of meetings? Every kind of meeting. That there was community meeting in Brooklyn, where there was a CEG meeting here, you know, with the members of the groups. Whether they went to a -- a community board meeting -- and I would hope that they would go to community boards seeking (inaudible) to tell them this and this and find out what people in the community and the community boards think we should be doing -- doing about SRJ.

Frequency of reporting? I mean, I do -- all of us do so many reports. We've got (inaudible) of reports. Unfortunately, for a position like this, it should be monthly reports. Each month we should be able to get a report over the outcomes of what that person, either in this building or out in the community. Yeah.

I guess I was acknowledging that we have created a lot of (inaudible) for all of the

people who contribute to the CEG, the workloads we have. We've had multiple contracting individuals. I guess I'd call this particular role as overseeing the broader process. So I would probably be more comfortable with (inaudible) and more frequency, but I guess I'm also thinking that if we had minutes of meetings, they should be descriptive outcomes, but tying that to the -- to the goals that the broader CEG agrees upon. So it might take some more time than a monthly reporting would.

I was actually thinking more in terms of internal, in a sense that someone in the Department of Health should have a monthly update as to how the person's doing. So that's what I meant by a monthly report.

In terms of the CEG, we -- we may have to move out to more time/space in terms of -- because even the CEG meeting monthly is labor intensive for the members of the community, not just whoever the contractor is. We'll have to rethink that, too, in terms of how often we meet.

But when it comes to reporting, the more information we have, the better decisions we

can make, so that's why I was thinking in terms of (inaudible).

MR. ANTHONY: Thank you. So our next question, how much and what type of interaction do you want the contractor to have with CEG members, community-based organizations, and other CEG consultants?

UNIDENTIFIED SPEAKER: I thought we answered that question already.

MR. ANTHONY: We can revisit.

MS. HART: Bobby Hart and this is question four. Interaction. Do you think CEG members, CBOs, and other CEGs? Thoughts and (inaudible).

I think that this person needs to be in the community in all boroughs. It would be great if there was a mechanism where there were quarterly town hall meetings in every borough to discuss their issues. So the listening sessions and the -- the community, whatever we had once in the past, it would be helpful to have us at least once a year, you know, in every borough and to be updated. Because communities are turning over so quickly and just people and populations in certain

communities have changed lately. And I think (inaudible) in central Harlem right now, (inaudible). I mean, take that back -- minority is changing quickly, you know. So the CEG contractor needs to be out in the community.

In terms of the types of interactions, it would be helpful, and I'm not say it's possible, but it would be helpful if the person was to actually go to community board meetings even if it's only once a year. But they need to make every meeting throughout all New York City, if it's only once a year, to find out what the members of community boards are thinking.

Should they meet with CBOs? They can meet with CBOs, but they should have CBOs come here. There's too many CBOs for them to be going and meeting with.

In terms of other CEG consultants, that's what I spoke to earlier. If there are other CEGs within the Department of Health, and I only stumbled across them by accident or I've met with some of them, I've talked with some of them, they're not doing anything like what

we're doing here. That SRJ CEG is really at the top in terms of community outreach and community engagement. That person doesn't have the skills to be involved in these various groups and communicating.

MS. ROBERTS: I guess I see it a little differently -- Lynn Roberts -- in terms of their level of community interaction. I suppose if we're looking for recruiting more members of the CEG, I see their role as much more internal to the process between whoever the CEG members are and the department policy staff. So for this contractor to be able to get to know those members and whoever they're tied to in the community and -- and who are specific SRJ consultants to the CEG consultants, which I interpreted that to mean coordinating their efforts so that it's the left hand knows what the right hand is doing, that there's regular communication, periodic convenings [sic] of all the consultants and facilitating that process.

So pretty regular. How that's done, whether through phone conversations or face-to-face meetings, probably some presence

in establishing rates, to have relationships with community organizations to be hosts to our meetings so that we can bring the CEG to the community and not just hear it at Gotham. But terms would be valuable in terms of (inaudible) to bring to the table.

MS. HART: Barbara Hart again. I'm hoping that it's not just one person. We're talking about a task that's going to take a minimum of three people to do. I mean, realistically, it confirms -- or the funds should be there so there's at least three members. It shouldn't just be one person to have all these things the two of us are saying. It would be overwhelming for one human being to do. But if it's at least three people, you know, one person and -- that have a staff of two others, I think it would work well.

MR. ANTHONY: Thank you. Question number five. This is our final question.

How many hours a week do you think this position should require?

MS. HART: Bobby Hart again. This is a full-time position. This is not a (inaudible) where somebody can just be 20 hours a week.

This is definitely a 35-hour-a-week job, possibly more. Unfortunately, everything in Department of Health is a full-time job. There's no such thing as part-time community work. I mean if you really want to do it, you jump whole heart and do it right.

So a minimum 35 hours a week. And I'm saying a minimum 35 hours a week for at least three people.

UNIDENTIFIED SPEAKER: I believe to manage it well, it should be 35 hours a week. I don't know how many people that would need to be spread over. I can see it as one person or multiple people doing that part-time out of that shared -- it's probably -- it's 30 -- it's (inaudible). (Inaudible.)

The other thing, we're talking about managing the various subcommittees as a whole, managing liaising between the community and the Department of Health, the community being -- to really do that accurately is time. It takes a lot of time to do. So I just want you all to take that into consideration. (inaudible.)

UNIDENTIFIED SPEAKER: Maybe I'm just trying to be realistic, but you should be

aspirational here. Right?

UNIDENTIFIED SPEAKER: Yeah. This is our wish list. We can tell them everything we want.

MR. ANTHONY: This is the end of our listening session. I want to thank you for your attendance and your input, valuable input.

If you have further questions, you can submit more responses to the questions that we discussed today. You can send them to the e-mail address on the slide. Thank you.

UNIDENTIFIED SPEAKER: So we get the slides from the (inaudible)?

MR. ANTHONY: And the transcript will be posted on our website. You can go to www.nyc.gov and search contract (inaudible) RSN.

UNIDENTIFIED SPEAKER: Is that different than the slides themselves? These slides.

MR. ANTHONY: Well, this is the -- our whole session will be posted. Whatever's recorded will be transcribed and posted onto this website.

UNIDENTIFIED SPEAKER: So in terms of if people that weren't here want to respond to the

questions, they have till October 26th. So I can go and tell my whole network people, you all need to do a favor and do this. I just need to write down that srj@gov.nyc for them to go to?

MR. ANTHONY: Yes. You can send a written response to this e-mail address (inaudible).

UNIDENTIFIED SPEAKER: How do they get the questions before that, though?

MR. ANTHONY: So you can send that out with the initial invite list, the questions. Just one last notification for the questions and the responses to that e-mail address.

MS. KAPLAN: This is Deborah Kaplan again.

When we send out the questions, we can also attach the PowerPoint with the questions so that as people are thinking if they have any other responses, they'll have that as a reference.

The transcript takes longer and so that's why we need to say it takes about a month. Because someone has to submit it, we have to review it. There could be inaccuracies. That takes some time. But we have the PowerPoint and we're okay to send that, which include the

questions to everyone we invited to this. All right.

MR. ANTHONY: Thank you very much.

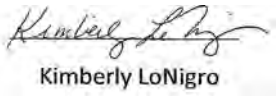
(Whereupon, the audio file ends at 56:23.)

C E R T I F I C A T E

I, Kimberly LoNigro, a Shorthand Reporter and Notary Public within and for the State of New York, do hereby certify that I listened to the audio recording that is the source of the foregoing transcription and to the best of my ability, this is an accurate transcription of the proceedings contained therein.

I further certify that I am not related to any of the parties to this proceeding by blood or marriage; and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have authorized LH Reporting Services to set my hand hereunto this 18th day of October, 2018.



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