Ending HIV/AIDS in the Latino Population in Minnesota

SUMMARY OF COMMUNITY STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS in the Latino Population in Minnesota

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Introduction

The Minnesota Departments of Health (MDH) and Human Services (DHS) convened 15 facilitated workshops around Minnesota to develop tactics for implementing the Minnesota HIV Strategy. The Minnesota HIV Strategy is a comprehensive plan to end HIV/AIDS. It includes five goals supported by 22 total sub-strategies (strategies) focused on how the goal will be achieved. The Minnesota HIV Strategy is available here: Minnesota HIV Strategy report (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf).

Each facilitated workshop focused on a specific region of the state or high-risk community. Workshop participants included stakeholders and community members with knowledge, connections, and insights about challenges and opportunities to support the success of this strategy. Wilder Research facilitated each workshop.

This is a summary of the facilitated workshop focused on ending HIV/AIDS in the Latino population. A workshop specifically focused on the Latino population was held because Latinos/Latinas are disproportionately impacted by HIV in Minnesota. While Latinos/Latinas make up 5 percent of the state's population, they accounted for 12 percent of new HIV infections and 10 percent of people living with HIV in 2017. The workshop was conducted on May 10, 2018, in Saint Paul, Minnesota. This summary also includes findings from a survey that was offered to individuals who were invited to participate in the workshop, but unable to attend.

Participants

Workshop participants

Thirteen people participated in the facilitated workshop. Table 1 shows the roles or areas of work participants identified when registering for the workshop. Participants could select multiple roles or areas of work.

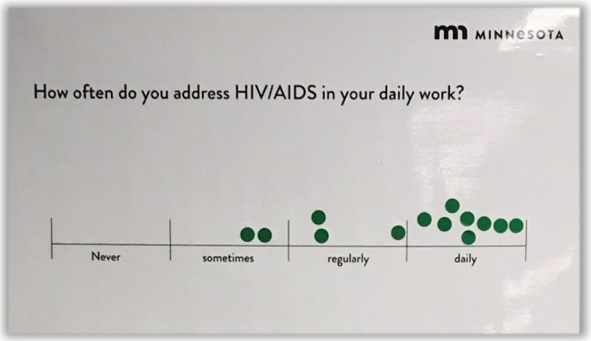
Table 1. Roles of workshop participants

	Workshop participants (N=13)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	3	23%
Chemical dependency provider	0	0%
City or county public health or human services professional	3	23%
HIV services provider	8	62%
Medical provider	0	0%
Mental health provider	0	0%
Social service provider	2	15%
Youth advocate/youth worker	1	8%
Other	2	15%
Unspecified or not pre-registered	2	15%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles. Staff from MDH, DHS, and Wilder Research also attended each facilitated workshop to present data on HIV in Minnesota, describe the Minnesota HIV Strategy, facilitate activities, answer questions, and take notes during small group discussions. The staff are not included in the table.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Workshop participants were asked to complete a visual survey question at the start of the workshop in which they answered the following question: "How often do you address HIV/AIDS in your daily work?" Responses ranged from sometimes to daily, with 8 of the 13 responses being daily.



Survey participants

Five people provided input via the survey. Table 2 shows survey participants' roles or areas of work. Again, participants could select multiple roles or areas of work.

Table 2. Roles of survey participants

	Survey participants (N=5)
Role or area of work	N
Advocate for, or member of, high-risk population[a]	1
Chemical dependency provider	0
City or county public health or human services professional	1
Faith leader	0
HIV services provider	0
Housing provider	0
Medical provider	2
Mental health provider	0
Social service provider	1
Youth advocate/youth worker	1
Other	1
Prefer not to answer	1
Missing	0

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Processes

Facilitated workshop process

Each workshop began with a presentation by MDH and DHS about the incidence and prevalence of HIV in Minnesota, a description of the Minnesota HIV Strategy, and a review of themes identified during a needs assessment conducted in 2017. The remainder of the workshop consisted of facilitated activities, led by Wilder Research, which helped participants to:

- Prioritize strategies that are most important for ending HIV/AIDS in the Latino population in Minnesota
- Develop tactics that would support implementation of high priority strategies

Throughout the workshop, note-takers documented participants' insights and ideas. This summary describes the strategies prioritized by participants and the tactics they identified.

Survey process

Individuals who were unable to participate in the workshop were able to contribute via a web-based survey. The survey asked respondents to identify the three strategies that they feel are most important for the population of interest, to recommend a tactic that addresses each strategy, and to identify barriers to implementing the tactic as well as resources that could support it. Survey responses are described alongside the feedback captured during the facilitated workshops.

Prioritized strategies

Strategies prioritized in the facilitated workshop

The goal of the first facilitated activity was to identify a set of high-priority strategies from the full set of 22 that are included in the Minnesota HIV Strategy. The activity included two rounds of prioritization. First, each small group of participants identified the four strategies they thought were most important for making progress toward ending HIV in the Latino population.

Second, after each small group shared their four selected strategies, all participants were able to vote for the one(s) they felt should advance to the tactic development stage of the workshop. Each participant was allowed four votes that could be distributed in any manner across any strategy that had been prioritized by at least one small group.

Across the four small groups working together during this workshop, 10 strategies were prioritized at least once. These are listed in Table 3. The four strategies that received the largest number of votes and advanced into the tactic development stage of the workshop are in bold.

Table 3. Prioritized strategies from workshop participants

Strategies
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.
Strategy 3.2: Ensure person-centered strategies that support long-term retention in care.
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.
Strategy 4.3: Ensure that people living with HIV (PLWH) and those at high risk of HIV infection have access to necessary supports that maintain their housing stability.
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.
Strategy 5.1: Create a leadership structure that is held accountable for implementing and updating this strategy. This leadership structure will include key stakeholders that this strategy affects, such as government leadership, community-based organizations, PLWH, and Minnesota residents that the HIV epidemic hits hardest.
Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services. An innovative culture includes recognizing that prevention and treatment options evolve and leadership must be willing to respond to new technologies to reduce HIV burden.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Some strategies may have received a large number of votes, but ultimately did not have enough participants interested in developing tactics to progress. These strategies are not in bold.

Strategies prioritized by survey respondents

Web survey respondents were also asked to identify strategies that they thought were most important for ending HIV/AIDS in the Latino population. Each survey respondent could identify up to three strategies they thought were most important. The most commonly selected strategies are shown in Table 4.

Table 4. Prioritized strategies from survey participants

Strategy	N (out of 5)
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), syringe services programs, and partner services.	3
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	2
Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services. An innovative culture includes recognizing that prevention and treatment options evolve and leadership must be willing to respond to new technologies to reduce HIV burden.	2

Note. The strategy numbers (e.g., 1.4) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least two people are included in the table; some strategies were prioritized by a smaller number of respondents.

Tactics

Tactics identified in the facilitated workshop

First, participants worked in small groups to brainstorm possible tactics for the four highest priority strategies highlighted in Table 3. Table 5 lists the tactics that were brainstormed for each of the strategies. The eight starred tactics (*) are the ones that participants recommended for integration in the Minnesota HIV Strategy.

Table 5. Brainstormed tactics from workshop participants

Prioritized strategies	Potential tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ Identify new community partners. ▪ Teach [organizations] how to write grants and how to disperse grant funding that is more equitable. ▪ Mandate [at the] state [level] and support the schools by dedicating resources to assist with providing k-12 sexual health education. ▪ Educate at each level of care to deliver the same messages to population served through languages that are culturally appropriate. ▪ [Develop a] public campaign and marketing strategies to address populations hardest hit by HIV. Multiple, but targeted messages and billboards that are culturally appropriate within communities. ▪ [Develop] language and education targeted to meet people's needs regardless of age or culture over the lifespan.* ▪ Actively participate in community events to make our presence known. Groups and active programs that provide services for culturally specific individuals. ▪ [Engage in] open discussions and education with community-based organizations/grantees by DHS, Hennepin County, and MDH. Allow for flexibility with funding and room to collaborate to create best practices as a collective group to really meet the needs of Latino, men who have sex with men (MSM), injection drug users (IDU), and LGBTQ people affected by HIV/AIDS. New partnerships and equitable disbursement of funding. Innovative partnerships to create a new approach to serving the needs [of the community]. Educate grantmakers and grantseekers with the shared vision of creating adequate/equitable/innovative sexual health partnerships and programming.*
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	▪ Engage community and recruit members of community. ▪ Utilize media platform. ▪ Include people in service delivery. "Nothing about us without us." * ▪ Create community ambassadors. ▪ Take down systems, shift cultural norms, address white folks--white people need to hold others accountable. "Dear White People."* ▪ [Conduct] culturally specific assessments, figure out what stigma looks like in each culture. Stigma varies across multicultural difference. ▪ Educate voters--who are you voting for?

Table 5. Brainstormed tactics from workshop participants (continued)

Prioritized strategies	Potential tactics
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.	▪ [Provide a] peer to peer support group that addresses mental health and substance abuse. Should be bilingual and have translation (have medical interpreter specialized in HIV education). Also use this space as a "focus group" as a way to hear from PLWH about what barriers they face. Have a built in feedback loop. ▪ Provide more formalized training for interpreters on HIV, and more training on HIV across the board. In conjunction with training on HIV, have education for the community and the providers on respecting transgender and LGBTQ community (lots of stigma in the Hispanic community - the biggest issue is with elders and newcomers to the country).* ▪ Train providers on culturally specific knowledge. ▪ [Have] trauma-related community discussion. Good food, good music, right place - have trauma related discussion all together with all races. ▪ [Provide] trainings for community on trauma. Culturally specific education and resources on talking about trauma. ▪ [Provide] funds for transportation. Taxis/staff able to provide a ride to support access to care. Not a bus - on weekends they are not consistent and will cancel. ▪ Build a network to share information - a holistic approach across organizations to provide information on resources like housing, mental health, chemical dependency, eating habits, etc. Share learning across cultural communities.*
Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services. An innovative culture includes recognizing that prevention and treatment options evolve and leadership must be willing to respond to new technologies to reduce HIV burden.	▪ [Provide] telemedicine for HIV care and PrEP (can be bilingual).* ▪ Use local public health more to integrate HIV policy. Needs to include education to Community Health Boards. ▪ [Develop] targeted web-based outreach to Latino MSM with incentives for testing.* ▪ Facilitate clinics that serve Latino community to become more HIV and STD competent--especially in rural Minnesota. Tele-medicine can also be used to train providers. ▪ [Provide] state government (MDH, DHS, Hennepin County) funding sources that are more coordinated and clear. Very interwoven, but chaotic now. ▪ Establish a state medical consultant for HIV (like the state TB consultant). Can be a resource for providers to become skilled and comfortable.

Tactics identified by survey respondents

Each survey respondent was invited to recommend a tactic that should be used to implement each of the strategies they selected as most important. Table 6 lists the tactics that they recommended.

Table 6. Recommended tactics from survey participants

Prioritized strategies	Recommended tactics
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	▪ [Provide] syringe service options. [Add] more community options for testing and treatment [and] more community providers. ▪ [Have] community HIV testing [provided] by Latin health advocates.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	▪ Offer community education and [create] media campaigns that address HIV stigma. ▪ [Have] HIV information including medication, appointments, and insurance information available in Spanish.
Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services. An innovative culture includes recognizing that prevention and treatment options evolve and leadership must be willing to respond to new technologies to reduce HIV burden.	▪ Increase Community Health Worker (CHW) and Public Health Nurse (PHN) staffing for outreach, education, testing opportunities.

Note. The strategy numbers (e.g., 1.4) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least two people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

Additional participant contributions

Workshop participants shared additional input throughout the facilitated activities. This input is described below.

- Participants provided feedback about elements of the Minnesota HIV Strategy.
- Participants expressed that strategy 2.4, specifically the part about systemic racism, can be seen in all aspects of this work. They noted that it interacts with all other strategies and is imbedded in our system and everyday work. They also noted that it should be at the front of the Minnesota HIV Strategy because it is such a big issue to tackle.
- Participants noted that, in relation to strategy 1.1, visibility is a big issue. They said that it would have been great if CLUES opened a clinic within the community on Lake Street, but this requires money.
- Strategies 3.1 and 3.2 stood out, especially because only 57 percent of Latino PLWH are virally suppressed. They noted that it was really important to keep people retained in care and get them virally suppressed.
- Latino community members living in Dakota County tend to seek services at La Clinica (located in Ramsey County), but that's the only option. This is not enough for people who are undocumented.
- Participants highlighted the specific stigma in the Latino community around being HIV-positive and gay.
- Participants noted that people without basic education are more difficult to get connected to care. They noted that there aren’t public campaigns about HIV, particularly in Spanish.
- Participants expressed overall concern about erosion of funding for sexual health education (both at national and state levels). They noted that this affects all communities.
- Participants recommended that MDH, DHS, and Hennepin County educate their grantees before awarding funds to ensure understanding of service commitment.

Next steps

Using the information from this summary, as well as other regional and community summaries and a statewide report of synthesized results, the Minnesota HIV Strategy Advisory Board will prioritize a set of tactics to be implemented. In fall 2018, MDH, DHS, and Wilder Research will prepare an implementation plan (including a fiscal analysis which describes the anticipated cost) and an evaluation plan to guide and monitor these efforts.

An updated Minnesota HIV Strategy will be submitted to the Minnesota Legislature by January 1, 2019. The update will include the most current data about the status of HIV/AIDS in Minnesota, information related to the outcomes of the facilitated workshops and web-based survey, the prioritized tactics, and the implementation and evaluation plans.

DHS is creating a new position to coordinate and report on the progress of the implementation and evaluation plans as well as progress in reaching the outcomes and indicators included in the Strategy. As tactics are successfully implemented in coming years, additional tactics will be prioritized and added to the implementation and evaluation plan.

At the end of the workshop and survey, participants were able to sign up to stay involved with, or support future work on, their recommended tactics if they are selected for the Minnesota HIV Strategy. Participants were also able to indicate other organizations or individuals who were unable to attend but should be included if the tactic moves forward. MDH and DHS will reach out to these individuals to request further input on or assistance with the tactic, as appropriate.

Lastly, workshop participants were encouraged to stay in touch with individuals they met during the workshop. They were invited to move forward with any promising tactics they identified that could be implemented with existing resources.

For additional information about developments in the Minnesota HIV Strategy, please visit Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html) or email Health.HIV.Strategy@state.mn.us.