

Ending HIV/AIDS Among Transgender People in Minnesota

SUMMARY OF COMMUNITY STAKEHOLDER INPUT

July 2018

Prepared by Wilder Research

Ending HIV/AIDS Among Transgender People in Minnesota

Minnesota Department of Health
Infectious Disease Epidemiology, Prevention and Control Division
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5414
[Minnesota HIV Strategy \(www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html\)](http://www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

Minnesota Department of Human Services
Disability Services
P.O. Box 65967
St. Paul, MN 55164-0967
651-431-4300
[Adults HIV/AIDS information \(https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/\)](https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/)

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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 \(www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf\)](http://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 among transgender people. A workshop specifically focused on transgender people was held because, according to current national estimates, approximately a quarter (22-28 percent) of transgender women are living with HIV and an estimated 56 percent of African American transgender women are living with HIV.¹ The workshop was conducted on May 16, 2018, in Minneapolis, Minnesota. A survey was also offered to individuals who were invited to participate in the workshop, but unable to attend. Only two individuals participated in the survey focused on ending HIV among transgender people. Due to the low response, survey data are not included in this summary.

¹ Clark, H., Babu, A.S., Wiewel, E.W., Opoku, J., & Crepaz, N. (2017). Diagnosed HIV infection in transgender adults and adolescents: Results from the National HIV Surveillance System, 2009-2014. *AIDS and Behavior*, 21(9): 2774-2783. doi: [Abstract publication among Transgender people \(https://www.ncbi.nlm.nih.gov/pubmed/28035497\)](https://www.ncbi.nlm.nih.gov/pubmed/28035497)

Workshop participants

Fifteen 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.

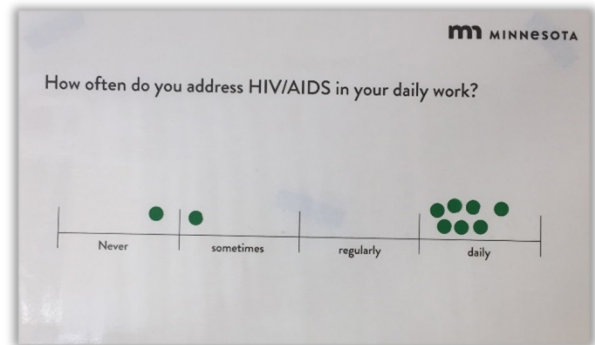
Table 1. Roles of workshop participants

Role or area of work	Workshop participants (N=15)	
	N	%
Advocate for, or member of, high-risk population ^a	8	53%
Chemical dependency provider	1	7%
City or county public health or human services professional	2	13%
HIV services provider	8	53%
Medical provider	1	7%
Mental health provider	1	7%
Social service provider	0	0%
Youth advocate/youth worker	1	7%
Other	1	7%
Unspecified or not pre-registered	1	7%

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 never to daily, with 7 of the 9 responses being daily.



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 among transgender people 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.

Prioritized strategies

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 among transgender people.

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 three small groups working together during this workshop, 13 strategies were prioritized at least once. These are listed in Table 2. During voting, however, the participants chose to vote for one of the overarching goals rather than the strategies. As such, the two strategies and one goal that received the largest number of votes and advanced into the tactic development stage of the workshop are in bold.

Table 2. Prioritized strategies

Strategies	
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	
Strategy 1.2: Increase routine opt-out HIV testing and early intervention services.	
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.	
Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing.	
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 3.5: Ensure access to services that meet the basic needs of people living with HIV (PLWH).	
Strategy 4.1: Identify gaps in affordable housing statewide.	
Strategy 4.2: Build partnerships that increase the supply of safe, affordable housing units for PLWH and those at high risk of HIV infection.	
Strategy 4.3: Ensure that 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.	<p>Goal 5: Achieve a more coordinated statewide response to HIV</p>
Strategy 5.5: Create effective information sharing partnerships and systems that produce reliable data and that inform decision-making, strategy development, and program accountability.	

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.

Tactics

First, participants worked in small groups to brainstorm possible tactics for the one goal and two strategies that received the greatest number of votes. Table 3 lists the tactics that were brainstormed for each. The six starred tactics (*) are the ones that participants recommended for integration in the Minnesota HIV Strategy.

Table 3. Brainstormed tactics

Prioritized strategies	Potential tactics
<p>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.</p>	<ul style="list-style-type: none"> ▪ Hire from the transgender community.* ▪ Develop medical strategies that are conducive to the patient's life and needs as a transgendered individual.*
<p>Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.</p>	<ul style="list-style-type: none"> ▪ Continue to build and keep money going into the right areas/organizations/agencies that are already supplying supportive housing so that they can expand housing opportunities. Have resources for housing (transportation, food, supplies, etc.).* ▪ Continue to build affordable houses (i.e., [requiring] 30% of income or less). Help maintain naturally occurring affordable housing at a reasonable cost (NOAH impact fund). Increase grants for housing providers to purchase property to keep it affordable. ▪ Allow for financing at a legislative level to provide housing/resources for long-term homelessness. [Use] Minnesota Housing Tax Credit financing. Expand the target population for supportive housing from just high priority homeless population to a broader array.* ▪ Take advantage of waiver for Medicare to fund supportive services (housing related services).
<p>Goal 5: Achieve a More Coordinated Statewide Response to HIV.</p>	<ul style="list-style-type: none"> ▪ Provide funding that is "open-source" (organizations define own goals, restrictions not imposed by grants). DHS, MDH, CDC pool funding and streamline process for grantees. Unify grant application process [to have] "coordinated entry" for grants.* ▪ Provide capacity-building, operating funds for small grassroots community-connected organizations to better compete for grants.* ▪ Push for transparency from MDH/DHS on projects and service delivery and resources. ▪ Eliminate zip code restrictions on people of color/marginalized populations for funding.

Additional participant contributions

Participants offered some additional feedback during the workshop. First, they noted that transgender representation is needed on the Minnesota Council for HIV/AIDS Care and Prevention. Additionally, they shared that building trust is a critical need. Transgender people face barriers to accessing care because of the stigma they face and because of previous trauma they have experienced. More transgender people should be employed in the field (rather than just served) to help improve this trust and reduce barriers to care.

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 \(www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html\)](http://www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html) or email Health.HIV.Strategy@state.mn.us.