

# Ending HIV/AIDS Among African Americans in Minnesota

SUMMARY OF COMMUNITY STAKEHOLDER INPUT

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Prepared by Wilder Research

## **Ending HIV/AIDS Among African Americans 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 \(www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf\)](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 African Americans. The workshop was conducted on May 24, 2018, in Minneapolis, Minnesota. A workshop specifically focused on the African American population was held because they are disproportionately impacted by HIV in Minnesota. While African Americans make up only 3 percent of the state's population, they accounted for 27 percent of new HIV infections and 21 percent of people living with HIV/AIDS in 2017. Only 73 percent of newly diagnosed African Americans are linked to care within one month of diagnosis, compared to 88 percent of whites. Compared to other racial/ethnic groups, African Americans have the lowest percentage of viral suppression at 55 percent. 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

Eighteen 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.

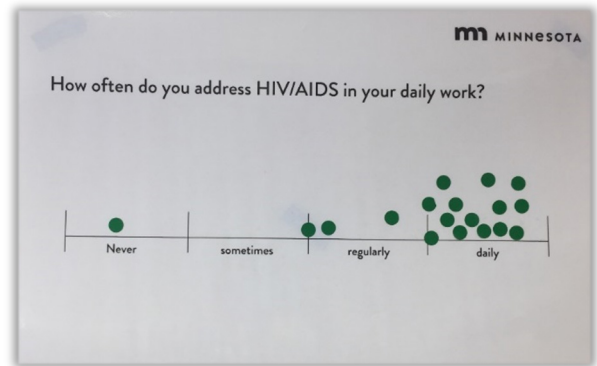
**Table 1. Roles of workshop participants**

Role or area of work	Workshop participants (N=18)	
	N	%
Advocate for, or member of, high-risk population <sup>a</sup>	5	28%
Chemical dependency provider	0	0%
City or county public health or human services professional	2	11%
HIV services provider	8	22%
Medical provider	1	6%
Mental health provider	1	6%
Social service provider	5	28%
Youth advocate/youth worker	0	0%
Other	3	17%
Unspecified or not pre-registered	3	17%

Note. The number 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.

<sup>a</sup> 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 14 of the 18 responses being daily.



## Survey participants

Nineteen 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**

Role or area of work	Survey participants (N=19)	
	N	%
Advocate for, or member of, high-risk population <sup>a</sup>	3	16%
Chemical dependency provider	0	0%
City or county public health or human services professional	3	16%
Faith leader	0	0%
HIV services provider	2	11%
Housing provider	1	5%
Medical provider	0	0%
Mental health provider	0	0%
Social service provider	0	0%
Youth advocate/youth worker	0	0%
Other	3	16%
Prefer not to answer	1	5%
Missing	7	37%

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

<sup>a</sup> 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 among African Americans 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 African American 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, nine strategies were prioritized at least once. These are listed in Table 3. The five 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 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.
<b>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.</b>
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.
<b>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.</b>
<b>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.</b>
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.
<b>Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.</b>
<b>Strategy 5.3: Identify, research, and replicate new, effective interventions through partnerships between local public health and state governments, tribal nations, HIV providers, community-based and religious organizations, the University of Minnesota and other academic institutions, research partners, and others.</b>



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 among African Americans. 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 19)	%
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.	7	37%
Strategy 2.2: Engage community leaders, non-profit agencies, people living with HIV (PLWH), and other community members to identify and to address barriers that prevent testing and person-centered care.	7	37%
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.	7	37%
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.	5	26%

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 five 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 five highest priority strategies highlighted in Table 3. Table 5 lists the tactics that were brainstormed for each of the strategies. The 10 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
<p><b>Strategy 1.4:</b> Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.</p>	<ul style="list-style-type: none"> <li>▪ Increase [the number of] providers who offer PrEP/PEP (pre- and post-exposure prophylaxis).*</li> <li>▪ [Implement] large scale advertising. [Hold] events for normalizing prevention.*</li> <li>▪ [Integrate] with work on Strategy 5.3 to develop culturally specific interventions.</li> <li>▪ Organize funding.</li> </ul>
<p><b>Strategy 2.4:</b> 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"> <li>▪ Add HIV to general conversations. Talk openly about it without shame, like talking to people about other health concerns like blood pressure.*</li> <li>▪ [Increase] awareness about how you respond to different things.</li> <li>▪ [Increase] understanding of the community, such as why this community is hard to reach and not trusting.</li> <li>▪ Use your voice, be comfortable, be vocal! If one person stands up, others will listen and follow! Continue cycle of education.</li> <li>▪ Hold leaders accountable. Call out leaders and vote them out if they are not following through with promises. Use your vote! Show up to meetings and workshops.*</li> <li>▪ Utilize social media to reach younger populations/generations. Incorporate messages into these forms of media to reduce stigma.</li> <li>▪ Educate frontline staff! People need to be consciously and culturally aware!</li> <li>▪ Stop letting white people make decisions for communities they don't engage with.</li> </ul>
<p><b>Strategy 3.3:</b> Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.</p>	<ul style="list-style-type: none"> <li>▪ [Implement a] culturally specific survey to identify what services are needed and to start a discussion.</li> <li>▪ [Provide] training and education with health care organizations, AIDS service organizations, and community-based organizations. Use common language.</li> <li>▪ Hire and train more bilingual staff.</li> <li>▪ Hire more staff who reflect the community they serve.*</li> <li>▪ [Create] culture-specific agencies, organizations, referral services.*</li> </ul>

**Table 5. Brainstormed tactics from workshop participants (continued)**

Prioritized strategies	Potential tactics
<p><b>Strategy 4.4:</b> Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.</p>	<ul style="list-style-type: none"> <li>▪ [Provide] flexible funding for rent (e.g., [a] pool of funds).*</li> <li>▪ [Offer] scattered-site housing, chosen by people living with HIV/AIDS.*</li> <li>▪ [Ensure that] diverse agencies disperse and receive funding.</li> <li>▪ [Provide] transportation from housing opportunities in Greater Minnesota.</li> </ul>
<p><b>Strategy 5.3:</b> Identify, research, and replicate new, effective interventions through partnerships between local public health and state governments, tribal nations, HIV providers, community-based and religious organizations, the University of Minnesota and other academic institutions, research partners, and others.</p>	<ul style="list-style-type: none"> <li>▪ Talk with community, church, and political leaders to educate them and learn what is working or is not working.*</li> <li>▪ Learn from other U.S. states/regions about how to disseminate accurate information and counter misinformation from social media.</li> <li>▪ Provide resources for organizations to work together to plan social events and educate (not just for World AIDS Day).*</li> <li>▪ Provide funding to small, appropriate organizations that can't afford grant writers.</li> <li>▪ [Develop partnerships between] health care providers and organizations like churches to complete rapid testing.</li> <li>▪ Work with organizations (and schools) to counter misinformation spread on social media.</li> </ul>

## 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
<p>Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.</p>	<ul style="list-style-type: none"> <li>▪ Coordinate between agencies/clinics conducting tests and person-centered care agencies.</li> <li>▪ Engage providers serving this community. Recruit more providers within the community to serve this community. Build on existing relationships with community groups.</li> <li>▪ [Locate] services at clinics and doctors' offices to immediately start working with people who are diagnosed.</li> <li>▪ Use trusted community persons to help connect individuals to care and treatment. Make sure cost concerns are addressed.</li> </ul>
<p>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.</p>	<ul style="list-style-type: none"> <li>▪ Identify where people of color (POC) congregate (e.g., social establishments, pride events).</li> <li>▪ [Improve] access to and availability of syringe services.</li> <li>▪ Have more people that look like and represent the people we are trying to reach out in the communities on a constant basis, not just when there is a need for data. Build relationships that people can trust. Offer incentives, transportation, non-labeled safe places for people to go and be tested or ask questions, etc. Have phone line information available for each targeted population.</li> <li>▪ Have these services available in prisons, high schools, junior highs, workhouses, job corps, etc. to educate and give services to especially young men and women of color.</li> <li>▪ Talk to people more in schools to educate and teach them how to take care of themselves better. Have more trained case managers and outreach workers who meet with people one on one.</li> </ul>
<p>Strategy 2.2: Engage community leaders, non-profit agencies, PLWH, and other community members to identify and to address barriers that prevent testing and person-centered care.</p>	<ul style="list-style-type: none"> <li>▪ [Hold] community conversations like you did for continued or ongoing conversation.</li> <li>▪ [Engage community-based individuals.] I will be repetitive. Just as one person cannot run another person's home effectively, so outside-of-the-community experts cannot address local community and individual needs effectively.</li> <li>▪ Engage African American leaders to target test their own community. Educate them about how to teach about HIV and then let them educate other folks of color.</li> <li>▪ [Use] social media for the biggest impact. Those communities that are at higher risk could and would be introduced to information on HIV in their local community. Since it is social media it would be able to be utilized without "outing" someone in public.</li> </ul>

Note. The strategy numbers (e.g., 1.3) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least five 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.

**Table 6. Recommended tactics from survey participants (continued)**

Prioritized strategies	Recommended tactics
<p>Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.</p>	<ul style="list-style-type: none"> <li>▪ Conduct community engagement with populations hardest hit by HIV to learn what they wish the tactic would be to remedy their situation.</li> <li>▪ Provide face-to-face interactions and phone line assistance. Allocate more funds to areas where the targeted populations live. [Have] full-time outreach efforts within the community with people who look like them.</li> <li>▪ [Increase] funding. [Use] Medical Assistance billable services.</li> <li>▪ Have HIV positive individuals speak at various agencies serving people of color. Give free education, condoms, and syringes.</li> <li>▪ Have a cocktail hour with free drinks to entice people to the location where a presentation can occur.</li> <li>▪ Talk to people who are receiving public benefits. Education is key.</li> </ul>

Note. The strategy numbers (e.g., 1.3) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least five 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.

## 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](mailto:Health.HIV.Strategy@state.mn.us).